

Board of Directors (In Public)

Schedule	Friday 25 September 2026, 9:15 AM — 1:15 PM BST
Venue	Northgate Room, 2nd Floor Quince House
Description	A meeting of the Board of Directors in the Public domain on Friday 25th September 2026
Notes for Participants	- Observer : Japhino Christo, Estates officer - Compliance - Rachael Scicluna-Penso, Integrated Services Lead, attending as part of CEO mentoring
Organiser	Joanne Sanger

Agenda

	AGENDA Presented by Jude Chin	1
9:15 AM	1. GENERAL BUSINESS Presented by Jude Chin	2
9:15 AM	1.1. Welcome and apologies for absence - Heather Hancock, Clement Mawoyo To Note - Presented by Jude Chin	3
9:20 AM	1.2. Declaration of interests for items on the agenda To Assure - Presented by Jude Chin	4
9:25 AM	1.3. Minutes of the previous meeting - 31st July 2026 (ATTACHED) To Approve - Presented by Jude Chin	5
	 Item 1.3 - 2026 07 31 July - WSFT Public Board Minutes - DRAFT.docx	6

	1.4. Action log and matters arising (ATTACHED)	21
	To Review - Presented by Jude Chin	
	 Item 1.4 - Board Action Log - 25.9.26 - Active.pdf	22
	 Item 1.4 - Board Action Log - 25.9.26 - Complete.pdf	23
9:25 AM	1.5. Questions from Governors and the public relating to items on the agenda (verbal)	24
	To Note - Presented by Jude Chin	
9:35 AM	1.6. Staff Story (includes reference to racist abuse) - Anita Perkins and Hannah Wray, Community Nurses in attendance	25
	To Review	
10:00 AM	1.7. Chief Executive's report (ATTACHED)	26
	To inform - Presented by Ewen Cameron	
	 Item 1.7 - CEO Board report - September 2026 v2.docx	27
10:10 AM	1.8. BAF and Risk Report (ATTACHED)	32
	To inform - Presented by Paul Bunn	
	 Item 1.8 - BAF report to Board - Sept 2026.docx	33
	 Item 1.8 - Org risk register Sep 2026 - please open and click link.docx	38
10:40 AM	2. JOINED UP SERVICES	39
	2.1. Strategic Priorities update report including reference to scorecard (ATTACHED) (+Appendix)	40
	Presented by Sam Tappenden	
	 Item 2.1 - Open Board Strategy Paper September 2026.docx	41

2.2.	West Suffolk Alliance, Norfolk & Suffolk ICB, and NHS Essex ICB (ATTACHED) Presented by Maddie Baker -Woods	52
	 Item 2.2 - WSFT Board EoL Paper 160926.docx	53
3.	HIGH QUALITY CARE	57
3.1.	Integrated Quality & Performance Report (IQPR) (ATTACHED) To Assure - Presented by Jude Chin	58
	 Item 3.1 - IQPR July 2026.pptx	59
10:40 AM	COMFORT BREAK (10 mins)	91
3.2.	Quality & Patient Safety Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Paul Zollinger-Read	92
	 Item 3.2 - QPS CKIs - August 2026.docx	93
3.3.	Nursing staffing report - including strategy (ATTACHED) To Assure - Presented by Daniel Spooner and Sarah Ward	97
	 Item 3.3 - Safer NMW Staffing July - August 2026 final.docx	98
3.4.	R&D annual report (ATTACHED) To Assure - Presented by Richard Goodwin	117
	 Item 3.4 - Research and Development Board Report.docx	118
3.5.	Maternity Services Report (ATTACHED) To Assure - Presented by Karen Newbury	122
	 Item 3.5 - September 26 Perinatal Quality Safety and Performance report.docx	123
4.	EMPOWERED TO IMPROVE	138

4.1. People & Organisational Development Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Heather Hancock	139
 Item 4.1 - CKI POD Aug 2026.docx	140
4.1.1. Gender, disability and ethnicity pay gap - (ATTACHED) (+Appendices) Presented by Sarah Hodds	149
 Item 4.1.1 - Disability pay gap report 2025-26 (Board Sept 2026).docx	150
 Item 4.1.1 - Ethnicity pay gap report 2025-26 (Board 2026).docx	158
 Item 4.1.1 - Gender pay gap report 2025-26 (Board Sept 2026).docx	175
 Item 4.1.1 - WDES report 2026 (Board Sept 2026).docx	184
 Item 4.1.1 - WRES report 2026 (Board Sept 2026).docx	215
4.2. Putting You First Awards - Anna Hollis (ATTACHED) To Assure	246
 Item 4.2 - PYF slides for Board Sept 2026.pptx	247
4.3. Freedom to Speak Up Guardian (Jane Sharland) (ATTACHED) To inform	252
 Item 4.3 - Board Report with Cover Sheet Q1 & 2 2026.27.docx	253
10:50 AM COMFORT BREAK (10 mins)	262
11:00 AM 5. RESPONSIBLE WITH RESOURCES	263

11:40 AM	5.1. Finance and Performance Committee - Committee's Key Issues (ATTACHED) To Assure - Presented by Antoinette Jackson	264
	 Item 5.1 - Finance and Performance CKI August FINAL.doc	265
	5.2. Finance Report (ATTACHED) To Review - Presented by Jonathan Rowell	270
	 Item 5.2 - Finance Board Report cover sheet M5.docx	271
	 Item 5.2 - M5 Finance report Public Board (2).pptx	273
	5.3. Winter Planning ATTACHED) (+Appendices) To Assure - Presented by Matt Keeling	287
	 Item 5.3 - Winter Planning for Public Board.docx	288
11:40 AM	6. FIT FOR TOMORROW	297
	6.1. Future system board report (ATTACHED) - Update on build - Update on transformation - Update on digital programme To Assure - Presented by Jonathan Rowell	298
	 Item 6.1 - WSFT Public Board PD Update september 26.docx	299
11:55 AM	GOVERNANCE	302
	6.2. Governance report (ATTACHED) To Assure - Presented by Paul Bunn	303
	 Item 6.2 Governance Report Trust Board Sept 2026.docx	304

	6.3. Annual Health & Safety Report (including fire incidents, complaints and claims) in review of modern slavery statement (ATTACHED) Presented by Jonathan Rowell	312
	 Item 6.3 - Health and Safety Annual Board report 2026.docx	313
	6.4. Agenda items for next meeting To Note - Presented by Jude Chin	320
12:15 PM	6.5. Reflections on meeting For Discussion - Presented by Jude Chin	321
	6.6. Date of next meeting - 27 November 2026 To Note - Presented by Jude Chin	322
	RESOLUTION The Trust Board is invited to adopt the following resolution: “That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960	323
	7. SUPPORTING APPENDICES To inform - Presented by Jude Chin	324
	Item 2.1 - Appendix	325
	 Item 2.1 - Appendix D - WSFT Strategic Scorecard September 2026.pptx	326

Item 4.1.1 - Appendices	341
 Item 4.1.1 - Appendix A pay gap action plan 2025.2026.docx	342
 Item 4.1.1 - Appendix B Menopause action plan (updated May 2026).docx	346
Item 5.3 - Appendices	352
 Item 5.3 - ANNEX A 20260917 WSFT Winter Plan Actions.pdf	353
 Item 5.3 - ANNEX B - BAS Self Assessment template.pdf	355
 Item 5.3 - ANNEX C 20260917 Winter Planning EIA.docx	361

AGENDA

Presented by Jude Chin

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Heather Hancock, Clement Mawoyo

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 31st July 2026 (ATTACHED)

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

MINUTES OF THE Open Board meeting

Held on Friday 31 July 2026, 09:15 – 13:15
Northgate Meeting Room, Quince House, WSFT

Members:		
Name	Job Title	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Dan Spooner	Executive Chief Nurse	DS
Richard Goodwin	Executive Medical Director/Board Level Maternity and Neonatal Safety Champion	RG
Jonathan Rowell	Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Julie Hull	Chief People Officer	JH
Antoinette Jackson	Non-Executive Director/SID	AJ
Heather Hancock	Non-Executive Director	HH
Richard Flatman	Non-Executive Director	RF
Alison Wigg	Non-Executive Director	AW
Michael Parsons	Non-Executive Director	MP
Paul Zollinger-Read	Non-Executive Director/ Maternity and Neonatal Safety Champion	PZR
Mike Knapton	Non-Executive Director	MK
Clement Mawoyo	Area Director, HomeFirst, Safeguarding and West Suffolk	CM
Maddie Baker-Woods	Executive Director, Primary Care and Neighbourhood Health for Suffolk	MBW
In attendance:		
Paul Bunn	Acting Trust Secretary	PB
Nick Macdonald	Director of Operational Finance	NMc
Matt Keeling	Deputy Chief Operating Officer	MK
Sarah Ward	Deputy Chief Nurse	SW
Karen Newbury	Director of Midwifery (Item 3.4 only)	KN
Simon Taylor	ADO, Women & Children and Clinical Support Services (Item 3.4 only)	ST
Kate Croissant	Clinical Director – Women & Children and Clinical Support Services	KC
Daniela Turner	EDI Midwife (Item 3.3 only)	DT
Melanie Osborne	Quality Improvement Manager (Item 1.6 only)	MO
Sarah Thirlby	Neonatal Governance Lead (Item 1.6 only)	STh
Nicola Kelly	Quality and Improvement Lead, Neonates (Item 1.6 only)	NK
Ruth Williamson	FT Office (minutes)	RW

Apologies: Richard Jones, Trust Secretary, Richard Flatman, Michael Parsons, Non-Executive Directors, Clement Mawoyo, Area Director, HomeFirst, Safeguarding and West Suffolk, Jonathan Rowell, Chief Finance Officer, Nicola Cottington, Chief Operating Officer, Julie Hull, Chief People Officer.
Governors observing:
Staff: Asha Rajan, Ward Manager Newmarket, Miguel Abreu, Operational Manager, Ophthalmology & Breast Surgery, Oluwatosin Adeyemi, Clinical Specialist Physiotherapist, Emma Dinnage, Student Doctor.
Members of the public: Gareth Peters.

1.0 GENERAL BUSINESS		
1.1	Welcome and apologies for absence	Action
	The Trust Chair (JC) welcomed attendees to the meeting. Apologies were noted, as detailed above.	
1.2	Declarations of interest	
	There were no declarations of interest for items on the agenda.	
1.3	Minutes of the previous meeting	
	The minutes of the previous meeting held on 5 June, 2026 were accepted as a true and accurate reflection, subject to the following amendment: Item 4.2 – Freedom to Speak Up Guardian: the meeting referred to was with the University of Cambridge, not as previously recorded.	
1.4	Action Log and matters arising	
	Action Ref 3205 – Strategic Priorities Update: ST confirmed that an update on the Strategic Priorities would be presented to the September Board meeting and reported quarterly thereafter. The action was closed. Action Ref 3206 – West Suffolk Alliance and Suffolk and North East Essex Integrated Care Board (SNEE ICB): Baseline for End of Life Care: MBW reported that the ICB was developing a suite of end of life care outcome metrics, including measures to address inequalities. A further update would be presented to the September Board meeting. The action was closed. Action Ref 3208 – Quality and Nurse Staffing Report: Staffing Levels: The Board noted that an update would be provided later in the meeting. The report offered assurance regarding staffing levels, focusing on quality governance and ensuring the right staff were in the right place at the right time. The importance of linking staffing levels to patient outcomes was noted and progress in this area was acknowledged. The matter had also been reviewed by the Quality and Patient Safety Committee. The action was closed. The Board noted the completed actions.	

1.5	Questions from Governors and the public relating to items on the agenda.	
	No questions were noted.	
1.6	QI Staff Story	
	The Board received a presentation from Sarah Thirlby (STh), Neonatal Governance Lead, and Nicola Kelly (NK), Quality and Assurance Lead for Neonates, on the application of Continuous Quality Improvement (CQI) within neonatal services. Melanie Osborne, (MO), Quality Improvement Manager, introduced the item, noting that maternity services provided an excellent example of successfully embedding CQI across a broad portfolio of improvement work. STh and NK outlined a project focused on undertaking intravenous cannulation at the cot-side wherever appropriate, reducing separation of mothers and babies and enabling parents to support and comfort their babies during procedures. The work formed part of a national quality improvement initiative to reduce mother and baby separation. The project had also improved the availability of appropriate clinical space, increased staff engagement, supported high-quality patient care and encouraged greater use of electronic documentation. The location of cannulation procedures had not previously been recorded on e-Care and this was being addressed through the project. JC commended the work and asked how the CQI approach would be developed further, including the role of training and mentoring others. NK advised that, through the ATTAIn programme, a new project was being developed to improve rates of babies receiving their first feed within the first hour after birth. She noted that there were always opportunities for further improvement. STh added that the team continued to learn and adapt as projects progressed. SJ asked about the impact on staff and whether there were plans to assess mothers' experiences. STh advised that whilst patient and family feedback was routinely sought, it could be difficult for families to recognise the significance of the change unless they had experienced the previous process. She emphasised that the key objective was to keep mothers and babies together, noting that babies had previously been separated from their parents for one to two hours, and sometimes longer, during procedures. Keeping babies with their parents supported bonding and family-centred care. MBW acknowledged that cannulation could be a challenging procedure to undertake with parents present and asked whether any difficulties had been experienced. STh reported that feedback had been overwhelmingly positive, with parents always given a choice about whether to be present. Very few chose not to be. NK added that there had been no significant difficulties and highlighted the benefits for clinical teams of undertaking procedures in a suitable environment with appropriate facilities and support from nursery nurses. She noted that the improved environment increased clinicians' confidence.	

	RG praised the work and observed that one of the key lessons from the project was that CQI should be viewed as an ongoing process rather than a finite piece of work. SJ reflected on the importance of quality improvement support and asked what barriers prevented wider participation in CQI initiatives. STh and NK identified fear and uncertainty as significant factors. They noted that regular support meetings and access to improvement coaching had helped maintain momentum and provided advice when required. NK explained that maternity services were promoting a culture of improvement from the outset of staff members' careers, including during preceptorship. Both presenters emphasised the importance of quality improvement advisory support, raising awareness that anyone could contribute to improvement work and encouraging new staff to bring forward fresh ideas. JC noted that quality improvement did not always require large-scale projects and could be achieved through the accumulation of smaller changes. NK agreed, highlighting that the project had been delivered using existing resources and without additional funding. RG emphasised the importance of making CQI part of normal practice rather than something viewed as separate or exceptional. AR reflected on personal experience of separation anxiety and asked about infection control considerations associated with bedside cannulation. STh confirmed that the clinical process remained unchanged and that no infection control concerns had been identified. EC welcomed the work undertaken to reduce mother and baby separation and thanked the team for their presentation. The Board commended the continued commitment to quality improvement within neonatal services.	
1.7	CEO Report	
	The Board noted the report presented by Ewen Cameron (EC), Chief Executive Officer. EC highlighted the success of Trust teams at the Norfolk & Suffolk Care Expo and recent achievements in education and training. Trauma and Orthopaedics had been recognised as the East of England Training Hospital of the Year, whilst Gynaecology had been identified as the most improved specialty nationally for education and training. JC noted that these achievements were reflected in resident doctor survey results and RG highlighted strong performance in the General Medical Council survey. JC emphasised the importance of recognising staff involved and EC confirmed that this had already been undertaken. PZR highlighted the importance of delivering the recovery plan, including financial and activity targets. JC noted that progress against the Cost Improvement Programme (CIP) and associated recovery actions would be considered further within the Finance Report and the Integrated Quality Performance Report (IQPR).	

	AW asked how the Trust had coped during the recent period of hot weather and whether any learning had emerged. EC reported that demand had increased significantly, particularly within the Emergency Department, resulting in a business continuity incident. EC advised that the estate infrastructure had experienced challenges, including loss of theatre capacity and that some areas of the organisation were more affected than others due to differences in cooling provision. JC noted the relevance of these experiences to discussions regarding the new hospital and future resilience to extreme weather. AJ added that the Green Plan agenda item addressed this issue. MBW noted that similar pressures had been experienced across primary care and community services and emphasised the need for year-round resilience planning across the system, rather than focusing solely on winter pressures. MK welcomed the work relating to staff standards, noting its importance and its inclusion within the NHS Oversight Framework as a key performance measure for the Trust. HH referred to the six staff standards domains and sought assurance regarding oversight and coordination of the associated work programmes. HH noted the significant volume of activity across the workforce agenda, including the Mann Review and the importance of ensuring a coordinated approach that would not overwhelm staff. The Board noted the report.	
1.8	BAF & Risk Report	
	The Board received the report presented by Paul Bunn (PB), Acting Trust Secretary. PB advised that the Board Assurance Framework (BAF) had been reviewed and was now being refined. No risk escalations were reported and the Board noted that the reporting arrangements were operating effectively. PB presented the proposed annual review of the Trust's risk appetite statements. A minor amendment was suggested to replace the term "hungry" with "eager". Most appetite statements remained unchanged, whilst the performance and workforce appetite statements had been revised. PB noted that the risk appetite framework would continue to evolve over time. HH sought clarification regarding BAF 5 and whether supply chain risks should be considered separately. PB advised that the risk was intentionally broad and encompassed a range of factors. He noted that consideration would be given to whether constituent elements, including workforce requirements and staffing implications associated with the new hospital, should be reflected separately.	

	MK asked how risk appetite would be embedded within business-as-usual processes and business planning. PB commented that, whilst not directly involved in the planning process, the framework would support more nuanced decision-making and prioritisation. ST added that it would provide a clearer lens through which to assess service and divisional risks. JC noted the importance of linking this work to service transformation planning. AJ supported the proposed risk appetite statements and agreed that the introduction of a specific performance risk appetite was appropriate. The Board approved the proposed amendment to replace "hungry" with "eager" and approved the revised risk appetite statements. In discussing the review schedule, members emphasised the importance of ensuring that mitigating actions were fully reflected in risk assessments and questioned whether some residual risk ratings remained higher than appropriate. The Board noted the position.	PB
2.0 JOINED UP SERVICES		
2.1	West Suffolk Alliance, Norfolk & Suffolk ICB and NHS Essex ICB	
	The Board noted that reporting had moved to a bi-monthly cycle and that the next report would be presented to the September Board meeting.	
3.0 HIGH QUALITY CARE		
3.1	Annual Review of IQPR	
	The Board received the report presented by Sarah Judge (SJ), Chief Information Officer. SJ emphasised that, as a report received in public, the Integrated Quality Performance Report (IQPR) needed to be accessible to staff, patients and the wider community. She also highlighted the increased focus on health inequalities within the report. SJ advised that the Business Intelligence Team had strengthened its reporting arrangements and was providing improved support for collaborative working across the organisation. The Board discussed whether the IQPR should move to an online dashboard format. SJ reported that feedback indicated the current presentation on the website was not displaying effectively in terms of visual presentation and usability and it had therefore been decided not to proceed at this stage. JC suggested that consideration be given to whether an online, real-time dashboard would be beneficial, with further discussion to be taken forward by the Executive Team. SJ noted the importance of ensuring that both the data and supporting narrative were accurate before any such development.	

	MK sought assurance regarding the relationship between Board reporting and divisional reporting arrangements. SJ explained that the IQPR was informed by reporting through the relevant assurance committees, with underlying data flowing through divisional reporting processes. She noted that data presented to divisions could differ slightly in format from that included within Board reports. The Board noted the report.	
3.2	Integrated Quality & Performance Report (IQPR)	
	Matt Keeling (MKe) presented the report. MKe highlighted that cancer performance was achieving the required standard, whilst Urgent and Emergency Care (UEC) performance remained challenging. EC sought assurance on elective recovery and asked why performance remained below plan. MKe advised that theatre capacity had now been fully restored and that, during the first full week of operation, activity had been only one case below the planned level. MKe explained that the focus was now on recovering activity lost during April, May, June and part of July. The Elective Delivery Board was meeting fortnightly to review leading indicators, maximise capacity and oversee delivery of the recovery plan. EC noted that elective underperformance was not limited to inpatient activity and referenced a 5% shortfall in outpatient performance. MKe advised that new outpatient activity was below plan, although follow-up activity was ahead of plan and outlined work being undertaken in response to GIRFT guidance on clinic templates and productivity. AJ referred to the Finance and Performance Committee's assessment of minimal assurance in relation to elective recovery during July and noted that this reflected the absence of a detailed recovery plan. PZR expressed concern that a detailed elective recovery plan had not yet been presented and sought clarification on when specialty-level trajectories and tolerances would be available. MKe confirmed that a comprehensive plan would be available within the following month and emphasised the importance of maintaining operational focus whilst developing the required level of detail. RG added that specialties were already reviewing performance data and that reporting arrangements continued to evolve to support improvement. MKe noted that the elective plan required delivery above the previous year's activity levels and that industrial action and delays associated with business cases had affected performance. He stressed that the organisation remained focused on recovering the activity deficit. JC advised that a fully developed elective recovery plan would be presented to the Finance and Performance Committee in	

	September, with consideration given to bringing it forward to August if possible. EC noted the importance of timely action to minimise the impact on performance during the remainder of the year. AW expressed disappointment with virtual ward utilisation and asked whether there was learning available from other organisations. MKe advised that utilisation was closely linked to operational pressures and that work was underway to improve consistency through strengthened clinical leadership. RG highlighted learning from other systems and noted that a wider programme of work was required, including closer collaboration with primary care colleagues and the establishment of sustainable leadership arrangements. EC advised that GIRFT clinical leaders had visited the Trust during the week as part of the New Hospital Programme and had offered support in relation to virtual wards. MBW also expressed willingness to support future developments, including exploring out-of-hours opportunities. AJ reported positive feedback from a recent paediatric 15 Steps visit and noted opportunities to revisit virtual ward models for children requiring intravenous antibiotics. EC commented that this would require a dedicated paediatric service and may not be cost effective within the existing model. ST noted that the success of virtual wards was dependent on clinical leadership and culture change and observed that no single model had yet been universally successful. PZR raised concerns regarding the community paediatrics waiting list and highlighted the potential risk of harm arising from delays in assessment and treatment. EC advised that this matter would be discussed further in the closed session and linked it to broader discussions taking place later in the day. PZR also sought assurance on progress in reducing postpartum haemorrhages and on improvement work within UEC. MKe advised that a Continuous Quality Improvement programme for UEC was being launched, supported by external expertise and informed by detailed data analysis. He noted that a surgical Same Day Emergency Care service was now operating at weekends. EC highlighted learning from discussions with another NHS organisation regarding UEC pathways and confirmed that this learning had been shared with the relevant teams. JC sought an update on community nursing performance and whether recent recruitment had reduced cancelled appointments. EC and DS advised that recruitment was progressing well, with a number of newly qualified staff expected to join from September. Whilst challenges remained, particularly in relation to third visits, work was underway to improve triage processes and prioritise patient need.	
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3.3	Staff Story – Daniela Turner, EDI Midwife	
	Dan Spooner (DS), Chief Nurse, introduced Daniela Turner (DT), EDI Midwife. DT outlined her work to reduce inequalities in maternity services, highlighting barriers relating to ethnicity, deprivation, language, digital access and neurodiversity. She described a range of initiatives to improve equity of access and personalised care, including enhanced interpreter provision, communication tools, coordinated appointments, reasonable adjustments, transport support and staff education. DT emphasised the importance of embedding EDI in all aspects of care and noted that national reviews continued to highlight inequalities across maternity services. She also described work to improve cultural awareness and inclusive practice and reported that the Trust was sharing learning and good practice with other organisations. JC thanked DT for her contribution and the positive impact of her work. GB congratulated DT on receiving a Putting You First award. In response to questions from PZR, DT identified interpreter provision and accessible transport as the two areas that would have the greatest impact on reducing inequalities. AJ welcomed the learning generated through the role and sought assurance that good practice would be shared more widely across the organisation. DS highlighted the importance of racial literacy and learning from lived experience. DT confirmed that training and staff engagement remained key priorities. KC and PZR raised concerns regarding digital connectivity. SJ advised that work was ongoing to improve coverage through infrastructure upgrades and targeted interventions. The Board thanked DT for her presentation and work on EDI.	
3.4	Quality & Patient Safety Committee – Committee’s Key Issues	
	Paul Zollinger-Read (PZR), Non-Executive Director, presented the report. PZR advised that the Committee had been able to provide only limited assurance regarding hand hygiene and medication safety. He emphasised that this did not indicate an absence of controls or poor outcomes, but reflected concerns regarding the robustness of assurance processes and audit arrangements. An action plan had been agreed to strengthen these areas. PZR reported that the Committee had received high-quality maternity reports and was able to provide partial assurance regarding progress against the Maternity 10-Point Action Plan. He highlighted the importance of triangulating information to support	

	assurance and noted that further work on this was being considered by the Committee. DS noted that hand hygiene audit processes had been revised to align with WHO standards, resulting in more realistic reporting whilst maintaining compliance rates in the high 90% range. DS also advised that medication safety governance had been strengthened through the establishment of a dedicated subgroup and reported that action was underway to address issues relating to medication lockers and estate infrastructure. JC noted that the discussion highlighted the importance of ensuring the Committee received the right evidence and assurance to support its assessments. HH welcomed the Committee's focus on understanding the factors underlying performance data, including workforce capability, safety culture and links to patient outcomes. PZR noted that further work was underway to strengthen understanding of both leading and lagging indicators. The Committee also discussed the use of proxy measures within maternity reporting. JC noted that consideration of appropriate indicators should continue through the assurance committee structure. EC reported that support had been offered through the Maternity Incentive Scheme and acknowledged concerns regarding administrative burden on clinical teams. MK highlighted the value of learning from examples of good practice, as well as from incidents and areas of concern. The Board noted the report.	
3.5	Nursing Staffing Report (including strategy) Dan Spooner (DS), Chief Nurse and Sarah Ward (SW), Deputy Chief Nurse, presented the report. DS highlighted recent workforce initiatives, including a Healthcare Support Worker Summit, improvements to staff redeployment processes and engagement with the Safer Staffing Faculty. In response to JC, SW advised that student nurse numbers were reducing nationally. The Trust was exploring alternative recruitment routes, whilst continuing to recruit successfully to adult nursing posts and substantively employ paediatric nurse trainees. PZR sought assurance on the relationship between patient acuity and staffing levels. SW explained that nationally recognised acuity tools were used routinely and that staffing levels were adjusted in response to patient dependency, acuity and enhanced care requirements. MK queried the value of Care Hours Per Patient Day (CHPPD). SW advised that CHPPD was a high-level metric and should be	

	considered alongside other staffing and quality indicators to provide a comprehensive assessment. The Board noted the report.	
3.6	Maternity Services Report Karen Newbury (KN), Associate Director of Midwifery, Simon Taylor (ST), Associate Director of Operations for Women & Children and Clinical Support Services and Kate Croissant, Clinical Director, Women & Children, presented the report. KN reported progress in response to the Ockenden and Amos reviews, including staff engagement events and work focused on culture and engagement. An independent review undertaken by the ICB and regional team had provided positive feedback, with several actions currently being progressed. JC noted that the ICB review had taken place shortly before publication of the Nottingham review. In response to a question from PZR regarding the Perinatal Toolkit, KC advised that existing programmes, including Saving Babies' Lives and current toolkits, continued to be used pending publication of the NHS England action plan. PZR asked about the potential use of AI-enabled translation tools. KN advised that discussions were taking place with Digital colleagues, although no clinically assured translation solution had yet been identified. SJ noted that opportunities were being explored alongside learning from other organisations, with particular challenges relating to medical terminology. AJ, KN and EC discussed the importance of ensuring information was communicated accurately and in language that was readily understood by patients and families. EC requested that future Friend and Family Test charts clearly identify the y-axis. KN agreed to amend future reports accordingly. MK highlighted the importance of learning from patient and family feedback and asked how services ensured all voices were heard, particularly where English was not a first language. KN advised that communication remained a key area of focus and highlighted the use of the Maternity Outcomes Surveillance System (MOSS) and other feedback mechanisms to identify emerging concerns and support further review where required. The Board noted the report.	
3.7	Fuller Report Dan Spooner (DS), Chief Nurse, presented the report. DS advised that the report followed the findings arising from mortuary reviews in Kent and reflected increased national scrutiny following the Ockenden Review, including concerns relating to care after the death of babies. He reported that a submission to NHS	

	England was required and that all actions remained on track for completion within the agreed timescales. DS highlighted the assurance statement requiring Board approval. He advised that most actions had been completed, with a small number of estate-related actions outstanding, including CCTV enhancements and equipment upgrades. Work on the Premises Assurance Model was progressing, with submission due by 8 September. DS confirmed that the assurance statement had been reviewed by the Quality and Patient Safety Committee. PZR advised that future oversight would be provided through the Mortality Assurance Group, with reporting to the Quality and Patient Safety Committee. The Board approved submission of the assurance statement to NHS England and noted the report.	
4.0 EMPOWERED TO IMPROVE		
4.1	People & Organisational Development Committee - Committee's Key Issues	
	Heather Hancock (HH), Non-Executive Director, presented the report. HH reported that work was underway to strengthen arrangements relating to sexual safety, including the appointment of a designated lead. The Committee had received a presentation on the Volunteer Service and noted the importance of considering volunteers within workforce planning and transformation programmes. HH advised that, following the Mann Review, the Trust had reaffirmed its zero-tolerance approach to inappropriate behaviours. The Committee reviewed the Staff Survey results, noting concerns relating to transparency, decision-making and communications, and discussed the importance of balancing staff perception with organisational context. HH also highlighted progress against the Resident Doctor 10-Point Plan. MK, as the Board's resident doctor lead, noted that the Trust was performing well regionally and emphasised the value of Non-Executive Director oversight in providing continuity and supporting resident doctors throughout their placements. DS clarified that the Band 5 Nursing Review was scheduled for 2028 rather than 2026. JC noted the significant number of workforce and organisational development initiatives underway and emphasised the importance of the Committee maintaining oversight to avoid initiative overload. The Board noted the report.	

4.2	Organisational Culture	
	EC reported that a Board workshop had been undertaken and advised that further work arising from the session would be developed and brought back to a future Board meeting.	
4.3	Putting You First Award	
	Greg Bowker (GB), Head of Communications, presented the report. EC noted that recognising and celebrating achievements with teams in their own work settings was particularly important, as it negated the need for staff working in the community having to travel to attend Board meetings. The Board noted the report and congratulated all award recipients.	
4.4	Lord Mann Review	
	Ewen Cameron (EC), Chief Executive Officer, presented the report. EC invited the Board to consider and endorse the recommended actions, with the exception of the recommendation relating to antisemitism, on which legal advice had been sought. Agreed EC to share the legal advice with Board members. AJ sought clarification on the legal challenge and whether it related specifically to healthcare settings. EC advised that the issue was broader than healthcare, although it had implications for healthcare organisations. MK asked whether the recommendation relating to antisemitism applied to staff, patients or both. EC confirmed that adoption of the proposed definition would apply to both patients and staff. EC further advised that the NHS England submission required organisations to confirm their position via a standard return, which did not provide scope for detailed commentary. AJ asked whether other organisations were taking a similar approach. EC advised that the Trust would not be alone in its position. The Board noted the report.	EC
5.0 RESPONSIBLE WITH RESOURCES		
5.1	Finance & Performance Committee – Committee’s Key Issues	
	Antoinette Jackson (AJ), Non-executive Director, presented the report the contents of which were noted and taken as read.	
5.2	Finance Report	
	Nick Macdonald (NMc), Director of Operational Finance, presented the report. NMc reported a year-to-date adverse variance of £900k against plan after the first three months of the year. The year-end forecast remained in line with plan, although delivery was dependent upon	

	elective recovery, recovery of lost income and achievement of the Cost Improvement Programme (CIP). NMc noted that, notwithstanding performance against plan, the Trust continued to report an underlying monthly deficit of approximately £300k. He advised that increased activity and delivery of the CIP would be required to eliminate the deficit position. The Board noted a non-pay overspend, primarily driven by difficulties in sourcing biosimilar drugs and associated cost pressures. Further work was underway to review high-cost drug expenditure and reimbursement arrangements. PZR sought assurance regarding delivery of the CIP and the level of schemes identified. NMc advised that a gap remained between the target and identified schemes, although work continued to develop workforce-related opportunities and other initiatives. ST reported that approximately two-thirds of the target had been identified, with 95-96% of schemes recurring in nature. He acknowledged that a significant gap remained and outlined work to accelerate delivery, including consideration of more challenging options. JC noted that the report demonstrated the progress made by the Trust. EC cautioned that significant risks remained. JC also highlighted the benefit of the payline and sought assurance regarding whether delivery would require additional workforce capacity or could be achieved within the existing establishment. The Board noted the report.	
5.3	Audit & Risk Committee	
	Jude Chin (JC), Chair, reported that the annual report and accounts had been approved and laid before parliament. The report was noted and taken as read.	
5.4	Charitable Funds Committee – Committee’s Key Issues	
	Jude Chin (JC), Chair, presented the report, the contents of which were noted. AW asked for an update on fundraising for the robot. MK advised that progress was being made, noting that the robot had been funded from reserves pending further fundraising efforts. AJ reported that £27,505 had been raised through Charitable Funds to date. JC requested that an update on the robot fundraising campaign be included with the Charitable Funds report presented to the Board in November.	RF

6.0 FIT FOR TOMORROW		
6.1	Future System Board Report	
	Nick Macdonald (NM), Operational Director of Finance, presented the report, which was noted and taken as read. NM advised that the contract with Dragados, builders of the new hospital, had been signed the previous day.	
6.2	The Green Plan	
	Nick Macdonald (NM), Operational Director of Finance, presented the report, the contents of which were noted and taken as read.	
6.3	Governance Report	
	Paul Bunn (PB), Acting Trust Secretary, presented the report. PB confirmed that there had been no audit escalations and that the Trust remained compliant with its statutory requirements. The Board approved the Terms of Reference for the Finance and Performance Committee. PB advised that the Annual Accounts had been laid before Parliament and asked Board members to review their Declarations of Interest and notify him of any required amendments.	
6.4	Agenda Items for Next Meeting	
	Jude Chin (JC), Chair, presented the report, which was noted and taken as read. JC requested that the Strategy Scorecard be included in the Strategic Priorities report to the September Board meeting.	ST
6.5	Reflections on Meeting	
	The Board congratulated EC on 30 years' service. ST welcomed the opportunity to hear directly from staff and reflected on whether there were sufficient opportunities for the Board to hear staff views collectively, noting that staff were keen to share their experiences and perspectives. Noted opportunities were provided through the Assurance Committees. AW suggested inviting comments from those in attendance at today's meeting. JC encouraged attendees to share their thoughts or, if preferred, separately after the meeting.	
6.5	Date of Next Meeting	
	25 September, 2026.	

1.4. Action log and matters arising (ATTACHED)

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3223	Open	31/07/2026	5.4	Charitable Funds Committee - Committee's Key Issues - update on robot fund raising to be included with CKI report to November Board.		RF	27/11/26	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3221	Open	31/07/2026	1.8	BAF & Risk Report - Risk Appetite Statement - amend "hungry" to "eager"	Actioned and communicated via CRGG for dissemination to Divisions.	PB	25/09/26	Complete	25/09/2026
3222	Open	31/07/2026	4.4	Lord Mann Review - share with Board Members legal advice sought regarding antisemitism recommendation.	Advice circulated.	EC	25/09/26	Complete	25/09/2026
3224	Open	31/07/2026	6.4	Agenda Items for Next Meeting - Strategy Scorecard to be included in Strategic Priorities Report to September Board Meeting.	Today's report refers (25.9.27)	ST	25/09/26	Complete	25/09/2026

1.5. Questions from Governors and the public relating to items on the agenda (verbal)

To Note

Presented by Jude Chin

1.6. Staff Story (includes reference to racist abuse) - Anita Perkins and Hannah Wray, Community Nurses in attendance
To Review

1.7. Chief Executive's report (ATTACHED)

To inform

Presented by Ewen Cameron

West Suffolk NHS Foundation Trust Board

Report information

Report title: Chief Executive Officer's report

Agenda item: 1.7

Sponsor/Executive lead: Dr Ewen Cameron, chief executive officer

Report prepared by: Dr Ewen Cameron, chief executive; Greg Bowker, head of communications; Anna Hollis, deputy head of communications; Sam Green, senior communications officer.

This report is for: ☐ Approval ☒ Assurance ☐ Discussion ☒ Information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

This report summarises the main headlines for July and August 2026.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

This report supports the Board in maintaining oversight of key activities and developments relating to organisational governance.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*

The items reported will be actioned through the appropriate routes.

Action required by the Board: The Board is asked to note the content of the report.

Governance and compliance

Risk and assurance: Failure to effectively manage risks to the Trust's strategic objectives.

Equality, diversity and inclusion: We have a duty to reduce inequalities.

Sustainability: Sustainable organisation

Legal and regulatory context: NHS Act 2026; Trust Constitution.

Chief Executive Officer's report

1. Introduction

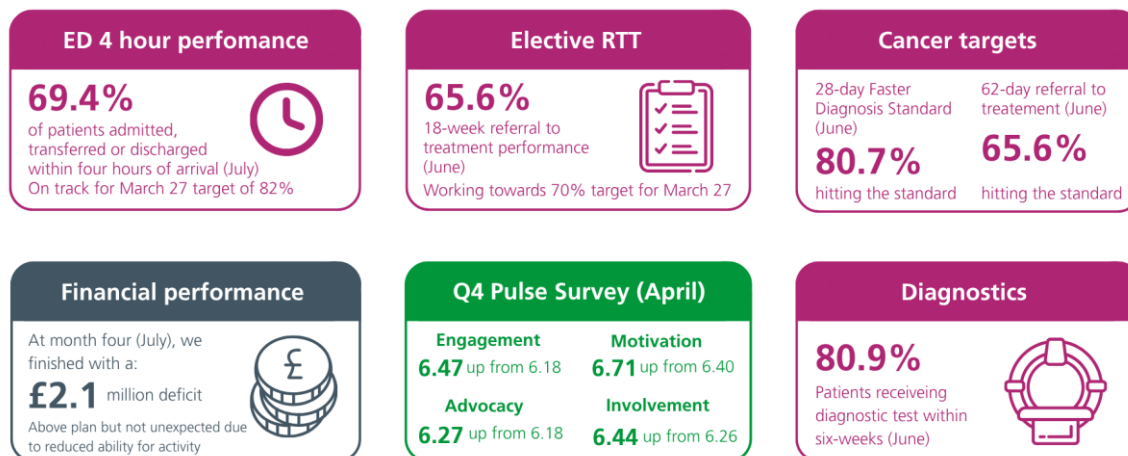
1.1. There will be talk soon of the 'winter pressure', where the NHS sees a significant increase in the demand for its services. While this remains true as we do still see an increase, it is important to point out there are no periods which allow us to fully catch our breath. We have experienced a challenging summer, with numerous record-breaking heatwaves meaning more patients than usual required our care. Previously, I have talked about us undertaking essential winter planning, and while this is ongoing, it reflects the different conditions under which we deliver care instead of a critical step in the process of making sure we maintain our services.

1.2. As ever, it is important our communities take the necessary steps to protect their health, and an easy way, is for them to get their annual flu vaccination. The 2026/27 flu campaign began on 1 September for children, pregnant women and some adults. The campaign will begin for all other cohorts, such as those aged 65 and older, on 1 October. This is a very simple way our communities can protect themselves and each other over the coming months, and I urge all those who are eligible for an NHS flu vaccination to get it at the earliest opportunity.

1.3. The NHS Oversight Framework is a league table which ranks every trust in England based on 14 metrics. There are five segments across the league table, which set out particular conditions we must meet to move between the segments. Due to our financial deficit, it is impossible for us to move out of Segment 3 to Segment 2 or 1. The NOF is updated every quarter, and we have remained in segment 3 since it began. In the latest update, we have retained our position in Segment 3, but have moved down slightly from 66 to 77. Given our position is relative, I don't have any concerns about this small change and know there is a huge effort to improve on all of the metrics that are recorded, regardless of the deficit plan limiting our potential to climb higher up the table.

Delivering compassionate care and healthier communities

Our performance highlights- July 2026



2. Financial performance

- 2.1. We are now in month five of the 2026/27 financial year, and we are continuing to work hard to meet our financial targets, as we have done previously.
- 2.2. Delivering more activity remains one of our top priorities as we are under a contract based on payment for activity rather than a block contract. Increasing activity is a critical part of how we will achieve financial success this year, as well as being extremely important for patients by bringing down waiting times.
- 2.3. As I mentioned last time, we have experienced difficult conditions so far this financial year, which include industrial action and extreme weather conditions, alongside planned theatre downtime for important upgrades. These have resulted in a slight reduction in activity, which in turn, impacts the revenue we generate. At the end of August, the Trust reported a deficit of £1.8 million, which is £717,000 above our planned position at this point in the year. However, we are working hard to deliver more activity to turn this around by the end of March 2027.

3. Performance

Elective recovery

Verbal update.

4. Quality

- 4.1. On Thursday, 17 September, we ran a free Community Health Connect Event, where a wide range of free health information, advice, and support was available, all under one roof. The event saw many from our community access free health checks for blood pressure and cardiovascular risks, bowel and breast screening, smoking cessation services, and support for carers and families with expert help from our maternity services. It was fantastic to hear how many people turned up to the New Bury Community Centre in Bury St Edmunds and we are looking to do more community engagement events in the future, which includes the frailty team's 'Ageing Well' event on Monday, 19 October 2026 at the Southgate Community Centre.
- 4.2. High Quality, Safer Care Week took place between Monday, 14 September and Friday, 18 September, which saw teams across the Trust shine a light on the importance of quality improvements in the care we provide our patients, and the way we engage with staff and enhance their experience at work. Taking place at the same time as national Quality Improvement Week, World Sepsis Day on 13 September, and National inclusion Week, our colleagues visited the quality improvement showcase stands and attended inclusion sessions, which aimed to further embed the culture of continuous quality inclusion across the Trust.

5. Workforce

- 5.1. Work on a project to restructure our divisions is now concluding, which will see our existing five divisions become four, where all existing teams will sit in either Medicine, Surgery and Anaesthetics, Community and Clinical Support Services, or Women, Children and Families. As part of these changes, each division will have a divisional director who will be a doctor, supported by an associate director of operations and an associate head of nursing / allied health professionals. We expect this new structure to be in place soon, and

we are working with the teams affected by any changes. I'd like to thank all those involved in these changes as a significant amount of work has been undertaken to get this project finished in a timely fashion.

5.2. At the last Board meeting, I mentioned that the Q2 Pulse survey was still open. The feedback we get through surveys like this is invaluable and gives us as a Board insight into what it's like working at our Trust, and the things that matter to our colleagues at all levels. We frequently talk about making sure when colleagues give us their thoughts we take action. I have read through every free-text comment provided, and there are clear themes where we will need to focus our attention going forward. Some of our colleagues feel the pressure to free-up capacity is driven by a desire to hit targets at the expense of the quality of care. As you will know, the reality is that failure to create capacity for admissions through our emergency department leads to worse outcomes and experience for our patients and that is what drives our efforts. This is why we are beginning a Trust-wide continuous quality improvement programme to improve flow through the system and make sustainable changes so that beds are available when needed for patients

5.3. I would like to thank every colleague who has given us their feedback through the last Pulse survey, and I encourage them to continue doing so. However, the annual NHS Staff Survey is launching on Monday, 28 September, and this is one of, if not the most important ways they can give us feedback. We will be sharing examples of the action we have taken over the past year since we received the results from the 2025 NHS Staff Survey, to encourage colleagues to take the time to complete this before it closes on Friday, 27 November.

6. Future

The project to deliver a new West Suffolk Hospital is making good progress. As I mentioned, the Trust has now been matched with its construction partner and can confirm Dragados Sociedad Anonima as the organisation who will work alongside us. In addition, we have submitted our Outline Business Case for the new hospital. These are important milestones for the programme and another step forward in the development of our future hospital. We now look towards the coming years and have greater clarity on the timeline of this project.

1.8. BAF and Risk Report (ATTACHED)

To inform

Presented by Paul Bunn

Open Board – 25 September 2026 – BAF update

Report information

Report title: Review of changes to the Board Assurance Framework (BAF)

Agenda item: 1.8

Sponsor/Executive lead: Ewen Cameron, CEO

Report prepared by: Paul Bunn, Acting Trust Secretary

Previously considered by:

This report is for: ☒ Approval ☐ Assurance ☐ Discussion ☐ information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What?

This paper provides an update on changes to the Board Assurance Framework (BAF) since this was last reviewed in July 2026.

As per **Appendix 1** (reporting schedule): BAF 3 Finance (loss of control); BAF 5 (Workforce); and, BAF 7 (Performance) were due for review since we last met. BAF 3 and 7 were presented to F&P in September 2026 noting the following:-

BAF 3 (Finance loss of control)

- Loss of deficit support funding has been included within C1 risk, although the risk is acknowledged to be low.
- Delivery dates for the new SBS system updated to 1 December 2026.
- Risk trajectory is predicted to achieve risk appetite in October (now December 26). The reasons for this are: SBS will bring a significant change to finance system processes, plus there is increasing confidence in achieving year end position.

BAF 7 (performance)

- Progress against mitigations updated to reflect enhanced governance through Elective Delivery Board; CQI project on eliminating emergency department 12 hour waits; and EPRR preparation and plans for mass casualty incident plans.
- Challenge around risk appetite trajectory. BAF 7 is not predicted to reach appetite over next 2 years. F&P queried if risk appetite is correct, or do mitigations need increasing? Whilst BAF reflects where we are now, future iterations of the BAF risk will focus on additional mitigations to include medium term plans; CQI projects on flow which will have a positive impact on risk trajectory.

BAF 5 has been deferred to October 2026 POD to enable the new CPO to reflect on the current BAF and to consider separating BAF 5 into: (i) supply chain, capability; and (ii) workplace staff experience to encompass EDI as discussed at the last development day.

Escalations

The internal audit recommended that the Board should specifically be made aware of any escalations/de-escalations to the BAF. There are none to report this month.

Appendix 2 maps the current and future predicted score for each BAF risk. Currently, BAF 5 (workforce), BAF 6 (quality of care) and BAF 8 (transformation) are at their risk appetite. The others are working towards this.

Workplan

BAF 6 (quality of care), BAF 2 (estates), and BAF 1 (cyber) are due for review in the next reporting period.

So what?

The BAF is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Failure to effectively identify and manage strategic risks through the BAF places the strategic objectives at risk. It is critical that the Board can maintain oversight of the strategic risks through the BAF and track progress and delivery.

What next?

- Continue to refine the BAF as per the reporting schedule.
- Link corporate (organisational wide risks) to the BAF.
- Work with senior leadership team to spread risk appetite themes into the divisions so that they can reflect thinking in business as usual and transformation projects when considering risk.

Action required by the committee:

Discuss and note the contents of this report.

Governance and compliance

Risk and assurance:

If WSFT does not have an effective risk management process in place, which includes: regular reviews of the BAF, and assessment and control of strategic risks, it will be unable to provide a positive statement within the Annual Governance Statement. This would impact its licence requirements.

Equality, diversity and inclusion:

Decisions should not disadvantage individuals or groups with protected characteristics as they apply universally throughout the Trust and comply with national standards for scoring risk.

Sustainability:

A properly managed BAF ensures WSFT will be fit for the future and able to meet the future healthcare needs of the population of West Suffolk. It will support the operational and strategic performance of WSFT. Identifying risks early and mitigating them may prevent occurrence or lessen their impact.

Legal and regulatory context:

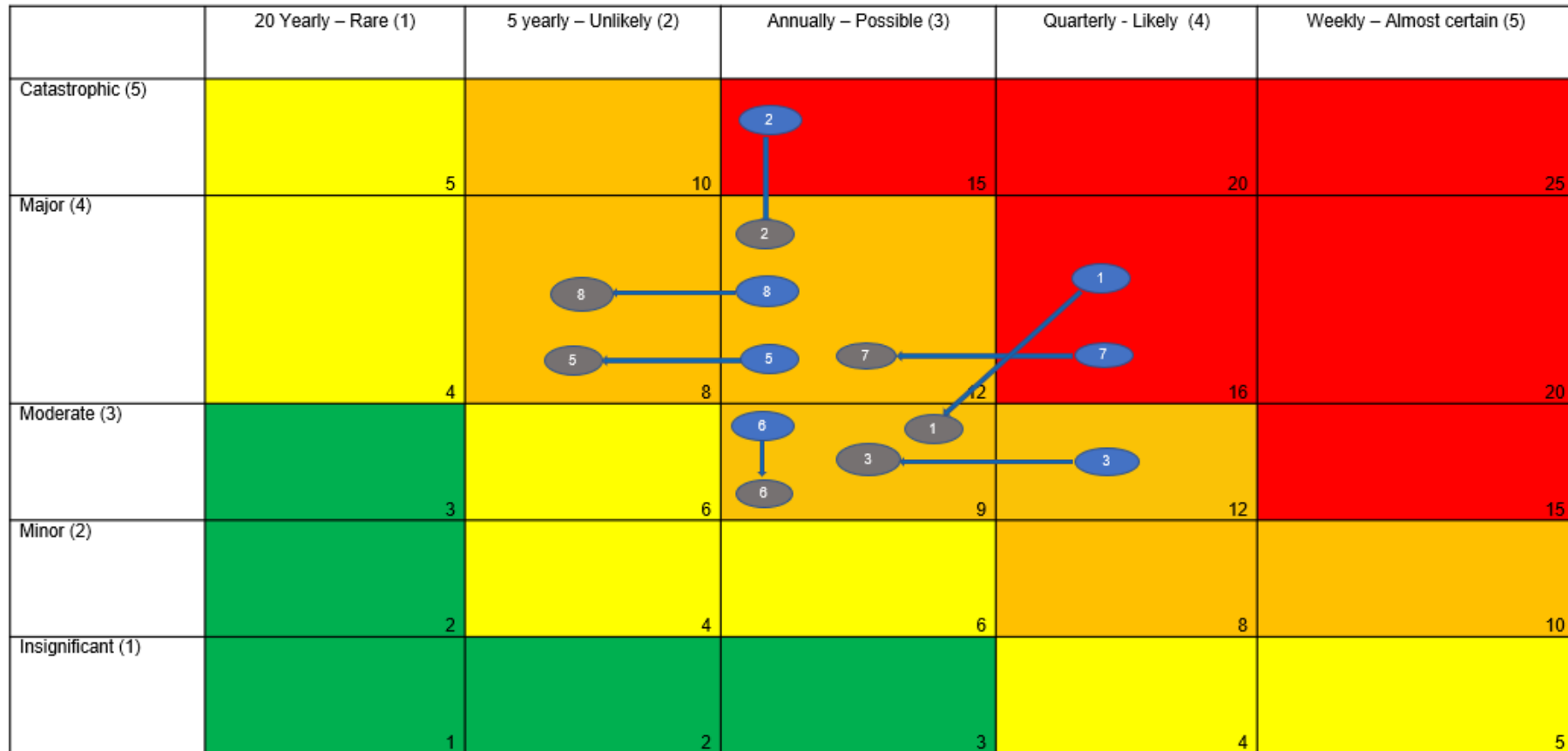
NHS Act 2006, Code of Governance. Well-led framework

Appendix 1

	Score	Frequency	Executive lead	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	Jul-27	Aug-27	Sep-27	Oct-27	Nov-27	Dec-27	Jan-28
Manangement Executive Group																							
BAF 1- Cyber	16	quarterly	COO (Nicola Cottington)		X		X			X			X			X			X			X	
BAF 2-Estates	15	quarterly	CFO (Jonathan Rowell)	X			X			X			X			X			X			X	
BAF 3-Finance	12	six monthly	CFO (Jonathan Rowell)	X						X						X						X	
BAF 4-TBC																							
BAF 5-Workforce	12	six monthly	CPO (Julie Hull)			X					X							X					
BAF 6-Quality of Care	9	six monthly	ECN (Dan Spooner)			X					X							X					
BAF 7- Performance	16	quarterly	COO (Nicola Cottington)		X			X			X			X			X			X			X
BAF 8- Transformation	12	six monthly	DST (Sam Tappenden)	X						X						X						X	
Quality and Patient Safety Committee																							
BAF 6 - Quality of Care	9	six monthly	ECN (Dan Spooner)				X					X							X				
BAF 8 - Transformation	12	six monthly	DST (Sam Tappenden)		X						X						X						X
Finance and Perfomance Committee																							
BAF 2-Estates	15	quarterly	CFO (Jonathan Rowell)		X			X			X			X			X			X			X
BAF 3-Finance	12	six monthly	CFO (Jonathan Rowell)		X						X						X						X
BAF 7-Performance	16	quarterly	COO (Nicola Cottington)			X			X			X			X			X			X		
People and Organisational Development Committee																							
BAF 5-Workforce	12	six monthly	CPO (Julie Hull)			X						X						X					
Digital and Data Committee																							
BAF1-Cyber	16	quarterly	COO (Nicola Cottington)		X			X			X			X			X			X			

Compassionate care,
healthier communities

Appendix 2 – BAF movement over time



Compassionate care,
healthier communities

[Item 1.8 - Risk Report September 2026.xlsx](#)

2. JOINED UP SERVICES

2.1. Strategic Priorities update report including reference to scorecard (ATTACHED) (+Appendix)

Presented by Sam Tappenden

Open Board

Report information

Report title: update on embedding the Trust's strategy

Agenda item:

Executive lead: Sam Tappenden, Executive Director of Strategy and Transformation

Report prepared by: Sam Tappenden, with contributions from Claire Lovatt, Assistant Director of Strategy and Transformation, Anna Hollis, Deputy Head of Communications, and Paul Bunn, Trust Secretary

Previously considered by: Closed Board

This report is for: ☐ Approval ☒ Assurance ☐ Discussion ☐ information

This report supports the following ambitions:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

The Trust's strategy, 'compassionate care, healthier communities', was approved in September 2025. Over the last year, the organisation has focused on embedding the strategy, delivering on the ambitions, developing enabling strategies, establishing governance arrangements, and strengthening the Trust's approach to strategy implementation and transformation delivery. This paper provides an update on:

- Improvements in staff awareness of the strategy
- Progress against the Trust's five strategic ambitions
- Implementation of enabling strategies through Board assurance committees
- Development of the Trust's strategic scorecard
- Progress refreshing the clinical care strategy

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

The strategy provides the framework through which the Trust prioritises resources, improvement activity and transformation programmes. Effective implementation is therefore essential if the organisation is to deliver its vision, mission, and ambitions.

The latest Pulse survey results are encouraging, showing improvements across all three strategy awareness measures. Positive awareness of the Trust strategy has increased from 44.1% to 53.1%, awareness of the five ambitions has increased from 63.8% to 74.9%, and awareness of how teams contribute to delivery has increased from 52.8% to 58.0%

What next? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*

The next phase of activity will focus on translating strategy into delivery through:

- Routine monitoring of progress against the five ambitions
- Embedding enabling strategies through committee oversight
- On-going review of the strategic scorecard
- Refresh of the clinical care strategy
- Continued development of the Trust's integrated transformation portfolio

Action required by the board:

- Note progress made implementing the Trust strategy.
- Note progress against the Trust's five ambitions.
- Support the continued embedding of strategy implementation arrangements.
- Discuss the proposed priorities for the next phase of implementation.

Governance and compliance

Risk and assurance: The refreshed strategy will enable the Trust's BAF to be updated, and in turn to ensure the organisation is addressing our strategic risks.

Equality, diversity and inclusion: A core tenet of the ambitions pertains to having an inclusive, supported, and valued workforce. The strategy included a renewed focus on EDI. An accessible 'easy read' version of the strategy document has been developed.

Sustainability: The strategy will play a critical role in delivering the Trust's financial sustainability through aligning Trust resources on key priorities.

Legal and regulatory context: A key role of the Board is ensuring the Trust has a robust strategy.

Update on embedding the Trust's corporate strategy

1. Purpose

- 1.1. The purpose of this paper is to provide the Board with an update on implementation of the Trust's corporate strategy, 'compassionate care, healthier communities', including progress embedding the strategy across the organisation, further developments in the strategy scorecard, and progress against the Trust's 26/27 priorities.

2. Executive summary

- 2.1. Since the update to Board in June 2026:
- There is on-going evidence of delivery success
 - Enabling strategies have been approved

- The strategic scorecard has continued to improve
- A PowerBI dashboard has been developed for one ambition
- The clinical strategy refresh approach has been agreed
- Staff awareness has improved by 9-11 percentage points
- Transformation governance embedded

2.2. Delivery during the first year of implementation remains aligned to the Trust's Renew roadmap, with progress evident across all five strategic ambitions and implementation arrangements now largely established

3. Progress against the Trust's strategic ambitions

- 3.1. Implementation of the strategy is increasingly focused on achieving measurable progress against each ambition. Key areas of progress by ambition are shown below:
- 3.2. **High quality care:** good progress is being made improving the quality, safety and accessibility of care. This includes continued improvements in key performance measures, implementation of the Trust's refreshed Continuous Quality Improvement approach, development of a Quality Management System, and refresh of the clinical service strategy to support delivery of high-quality and sustainable services.
- 3.3. **Joined-up services:** The Trust continues to strengthen integrated care and partnership working across West Suffolk. Progress has been made developing and supporting new models of care closer to home, including the Integrated Diabetes Service, Care Management Service and continued development of neighbourhood health and partnership arrangements.
- 3.4. **Empowered to improve:** Progress continues to be made strengthening organisational culture, leadership and improvement capability. Key developments include implementation of the workforce strategy, launch of Empower U, embedding of the accountability and autonomy framework, planning the implementation of the Trust's divisional leadership restructure, and continued work to support colleague wellbeing, inclusion and engagement.
- 3.5. **Responsible with resources:** The Trust continues to focus on improving financial sustainability, productivity and organisational efficiency. This includes delivery of the Medium-Term Plan, implementation of the Finance Strategy, strengthening financial and workforce planning arrangements, and maintaining focus on productivity improvement and delivery of cost improvement programmes.
- 3.6. **Fit for tomorrow:** Progress is being made modernising services, infrastructure and decision-making capability. Key developments include implementation of the Digital and Data Strategy, progress with the data warehouse programme, deployment of emerging technologies such as Copilot and Ambient Voice Technology, and continued preparation for future service transformation through the Future Systems Programme.

- 3.7. Detailed progress against each ambition, including strategic priorities, key measures, recent performance and actions, is provided within the latest strategy scorecard in **Appendix D**.

4. Progress against the ‘recovery, renew, reimagine’ three-year roadmap

- 4.1. Delivery during 2026/27 remains very much aligned to the ‘Renew’ phase of the strategic roadmap:

Table 1: summary of progress against the Trust’s strategic roadmap

Renew commitment (2026/27)	Progress update
Launch high-impact service changes for patients with the greatest needs	Care Management Service mobilisation underway; Trust-wide flow QI programme launched; Quality Management System development underway which will empower colleagues with the support and tools to make improvements.
Launch services that shift care closer to home	Launching Shared Service Delivery model end of September; supporting development of Integrated Diabetes Service with the ICB; preparation for community contract renewal underway; and various new pathways (e.g. heart failure) being embedded.
Accelerate adoption of digital technologies	Ambient Voice Technology pilots completed and evaluated; data warehouse programme progressing; transformation of administration programme progressing.
Develop new ways of working with partners	Partnership strategy developed; developing proposals with partners to enhance relationships, particularly primary care; developing approach to innovation adoption with Health Innovation East (HIE).
Deliver a near-balanced financial position	Improvements in financial systems underway; first medium-term plan submitted and accepted; significant CIP delivery underway; forecasting to achieve our planned deficit position.

5. Board Assurance Framework

- 5.1. During 2026 the Trust refreshed its Board Assurance Framework to strengthen the alignment between strategic risks, strategic ambitions and organisational priorities.
- 5.2. A new transformation-focused risk (BAF 8) was established, recognising the risk that the Trust is unable to deliver the scale of change required to remain clinically, operationally and financially sustainable over the longer term.
- 5.3. The implementation of enabling strategies, the integrated transformation portfolio, strategic scorecard and strengthened governance arrangements represent key mitigations for this risk and provide improved Board oversight of delivery

6. Enabling strategy development

- 6.1. All 'enabling' strategies have now been approved and are being embedded through existing Board assurance committee structures, with the exception of the clinical service strategy which is planned for completion in March 2027.
- 6.2. Intranet pages for all other enabling strategies have been created on the intranet for web accessible versions as previews awaiting approval by strategy owners before publication.
- 6.3. Assurance committee review cadence will be six monthly in line with BAF reporting schedules, with review at PRM one month before for local monitoring and mitigation. This represents an important shift from strategy development to strategy delivery.
- 6.4. Formal assurance committee review will be introduced six months post launch or 'go live' date of each strategy as a phased approach. This has already commenced for digital and data and MyWiSH strategies.
- 6.5. Assurance committee review arrangements are as follows:

Table 2: enabling strategy review dates by committee

Enabling strategy	Executive owner	Committee	Commencement date
Clinical service strategy	Executive Chief Nurse/ Executive Medical Director	Quality and Safety Committee	Sept 2027
Research strategy	Executive Medical Director	Quality and Safety Committee	March 2027
Finance strategy	Executive Chief Finance Officer	Finance & Performance Committee	Jan 2027
Estates and facilities strategy	Executive Chief Finance Officer	Finance & Performance Committee	Jan 2027
Digital and data strategy	Chief Operations Officer	Digital & Data Committee	Commenced
Partnerships strategy	Executive Director for Strategy and Transformation	People and OD Committee	Jan 2027
People, culture and OD strategy	Chief People Officer	People and OD Committee	Feb 2027
Communications and engagement strategy	Chief People Officer	People and OD Committee	Feb 2027
MyWiSH strategy	Chief People Officer	Charity Committee	Commenced

- 6.6. The enabling strategies now provide a clear line of sight between the Trust's corporate ambitions, departmental priorities, planning, transformation programmes and committee assurance processes, as shown in the visual below.



7. Clinical service strategy

- 7.1. Work is underway to refresh the Trust's clinical service strategy and align it fully with the corporate strategy, business planning, Future Systems Programme, financial sustainability requirements and emerging Quality Management System.
- 7.2. The refresh recognises that whilst the current strategy remains directionally sound, future clinical development requires clearer planning assumptions relating to workforce, finance, productivity, quality, estates and the Future Systems Programme.
- 7.3. The proposed refresh will deliver a clinical service strategy, jointly sponsored by the Executive Medical Director and Executive Chief Nurse respectively, setting out strategic objectives, design principles and planning parameters for future service development.
- 7.4. The refresh is being delivered in two phases aligned to the Trust's roadmap. Phase 1, to March 2027, focuses on confirming the strategic direction, design principles, planning assumptions and stakeholder engagement, culminating in approval of the strategy in March 2027.
- 7.5. In July 2026, the Trust commenced this engagement with the Senior Leadership Team (SLT), to inform the strategy. Initial discussions identified broad support for the overall direction of travel but highlighted a need for greater clarity regarding how strategic ambitions will be translated into practical service changes.
- 7.6. During this period, the Trust will test proposals with staff and partners, refine planning assumptions, and ensure alignment with the strategic scorecard, transformation portfolio, and business planning.

- 7.7. Phase 2 will be delivered through the 2027/28 business planning cycle and will focus on the development of clinically-led, evidence-based and financially sustainable future service models.
- 7.8. See **Appendix C** for more information.

8. Strategy reporting

- 8.1. Board approved the Trust's strategic scorecard approach in June 2026. The scorecard provides a structured mechanism for monitoring delivery of the Trust's 15 strategic priorities and strengthening accountability for implementation.
- 8.2. Work is now focused on embedding the scorecard within routine governance and reporting arrangements.
- 8.3. A Power BI proof-of-concept has been developed and the first digital version, focused on a single strategic ambition, with a screenshot available in **Appendix A**.
- 8.4. Subject to agreement, this approach will subsequently be expanded across all five ambitions. There are a small number of measures that require a baseline given their relatively recent adoption; these will be finalised as soon as practicable.

9. Embedding the strategy

- 9.1. The Trust has continued to embed the strategy through communications, leadership engagement, governance processes, planning arrangements and committee oversight. The most recent Pulse Survey provides encouraging evidence that awareness of the strategy continues to improve.

Table 3: strategy awareness survey results

Question	Jan 2026 Positive	Jul 2026 Positive	Change
I am aware of the Trust strategy 2025-2028, 'compassionate care, healthier communities'	44.1%	53.1%	+9.0%
I am aware of the five ambitions within the Trust strategy	63.8%	74.9%	+11.1%
I am aware of how my role/team contributes to delivery of the strategy	52.8%	58.0%	+5.2%

- 9.2. These results demonstrate positive movement across all three measures. Awareness of the strategy itself and the five ambitions has improved significantly, whilst awareness of how individual teams contribute to delivery continues to improve.

- 9.3. Whilst further work is required to strengthen the connection between the strategy and local objectives, improvement activity and day-to-day delivery, the overall direction of travel remains positive.
- 9.4. Further detail on divisional-level awareness of the strategy can be found in **Appendix C**.

Table 4: progress in activities by phase to embed the strategy

Phase	Roadmap	Timescales	Focus	Activities	Status
One: launch	'Recover'	Oct '25 – Feb '26	Awareness of internal and external stakeholders	General communication through key channels (e.g. All Staff Update), development of key materials (e.g. posters), and case study collation.	Complete
Two: spread	'Renew'	Feb '26 – Jun '26	Integration into strategic processes	Digital briefing and briefing packs for teams to cascade Continuous regular staff communications (e.g. ASU) Continuous Quality Improvement approach Launch the complete strategic framework (i.e. enabling strategies) Embed in planning, decision-making, and governance.	Complete
Three: embed	'Renew'	Jul '26 – Dec '26	Behavioural and cultural adoption	Continuous regular staff communications (e.g. ASU) Embedding the strategy in Trust events e.g. AMM and Health Connect public engagement Incorporate into organisational BAU processes: - Appraisals, objective setting, leadership programmes - Complementary launch of values and behaviours framework - Continuous Quality Improvement approach - Operational governance (e.g. divisional boards).	Planning
Four: sustain	'Reimagine'	Jan '27 and beyond	Continuous activities to sustain awareness	On-going activities to sustain engagement include:	Ongoing

				• Continuous regular staff communications (e.g. ASU) • Embedding the strategy in Trust events • Continuous Quality Improvement approach.	
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10. Key implementation priorities

10.1. The focus for the remainder of 2026/27 will be on translating strategic intent into delivery and outcomes in line with the 'renew' roadmap. The priority areas are:

- Embedding enabling strategies through assurance committees
- On-going review and development of the strategic scorecard
- Completion of the clinical service strategy refresh
- Further development of the integrated transformation portfolio
- Strengthening benefits realisation and programme assurance
- Continuing to improve colleagues' understanding of the strategy

11. Summary and next steps

11.1. Good progress has been made during the first year of implementation of 'compassionate care, healthier communities'.

11.2. Enabling strategies have been approved, a new BAF has been developed, the strategy scorecard provides increasingly firm oversight of progress, staff awareness is improving, and most importantly, progress is being recorded against each of the five ambitions.

11.3. The next phase will focus on maintaining momentum, strengthening delivery and ensuring that the strategic framework translates into on-going improvements for patients, communities and colleagues.

11.4. As the Trust enters the second year of implementation, it is proposed that the Board undertakes an annual review of the corporate strategy through a Board Development Session in October.

11.5. The purpose would be to review:

- Progress made to date
- Whether the ambitions and priorities remain appropriate
- Changes in the national and local environment
- Emerging opportunities and strategic risks
- Any adjustments required to our strategic priorities

11.6. This approach would be consistent with good governance and ensure the strategy remains dynamic, relevant and outcome-focused.

12. Recommendations

12.1. Note progress implementing the Trust strategy.

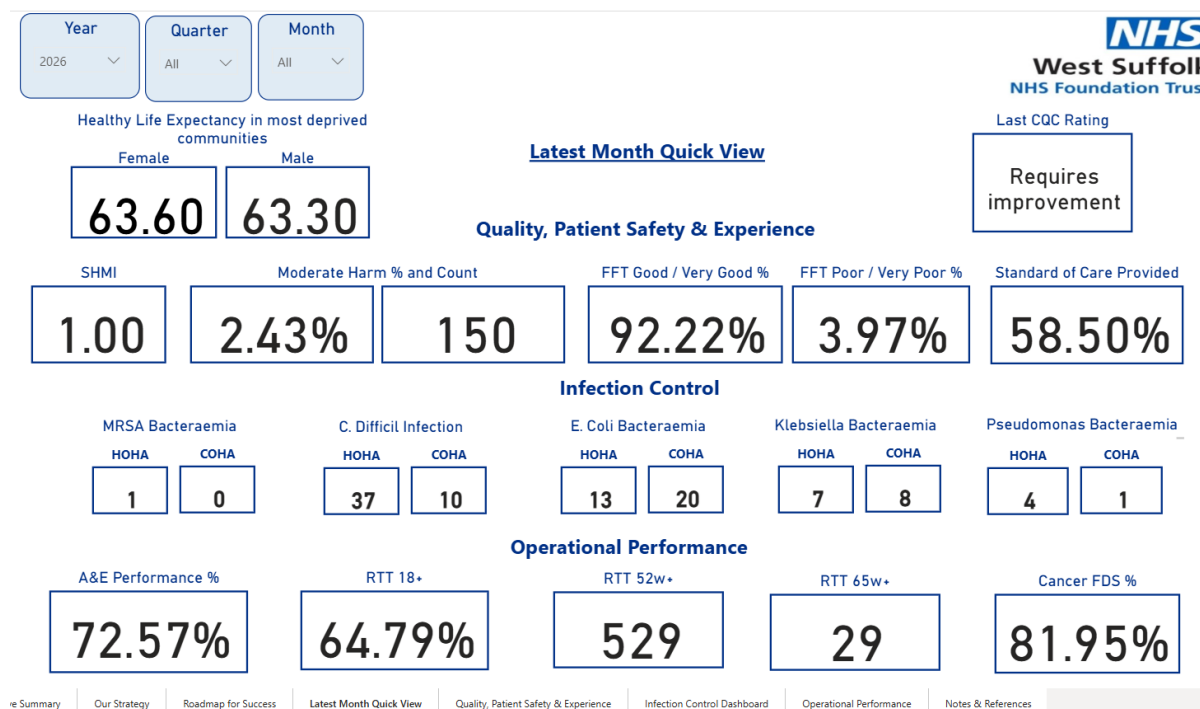
12.2. Note the improvement in staff awareness of the strategy.

12.3. Note progress against the Trust's five strategic ambitions.

12.4. Support the continued implementation of enabling strategies, strategic scorecard reporting and the clinical service strategy refresh.

12.5. Undertake an annual review of the strategy through Board.

Appendix A – screenshot of draft dashboard for ‘high quality care’ ambition



Appendix B – Clinical service strategy refresh timescales

Period	Activity	Output
Jul-Sep 2026	Initial engagement and strategic discussion	Validation of objectives, principles and ambitions
Sep-Nov 2026	Staff, patient and partner engagement through existing forums	Refined strategic framework and feedback themes
Nov 2026-Jan 2027	Development of planning assumptions and design parameters	Agreed planning framework
Jan-Feb 2027	Draft Clinical Service Strategy	Board review and final refinement
Mar 2027	Approval of Clinical Service Strategy	Approved enabling strategy
Apr 2027 onwards	Service model development through business planning	Transformation programmes and service redesign plans
2027/28	Implementation of agreed priorities	Delivery of future clinical models

Appendix C – divisional awareness of the Trust’s strategy

I am aware of our strategy 2025-2028 - Compassionate care, healthier communities				
Division	Positive (%)	Neutral (%)	Negative (%)	No. of respondents

Clinical Support	46.8	27.9	25.2	111
Community	57	22.5	20.4	142
Corporate services	65.1	18.3	16.5	175
Estates and Facilities	50	23.1	26.9	52
Medical	40.2	28	31.7	82
Surgical	44.9	31.9	23.2	69
Woman and Children	51.4	40	8.6	35
Prefer not to say	49.1	28.3	22.6	53

I am aware of the five ambitions that sit within our Trust strategy

Division	Positive (%)	Neutral (%)	Negative (%)	No. of respondents
Clinical Support	82	6.3	11.7	111
Community	71.1	16.2	12.7	142
Corporate services	78.9	8	13.1	175
Estates and Facilities	75	11.5	13.5	52
Medical	74.4	17.1	8.5	81
Surgical	63.8	27.5	8.7	69
Woman and Children	91.4	5.7	2.9	35
Prefer not to say	60.4	28.3	11.3	53

I am aware of how my role/team contributes to the delivery of the Trust strategy

Division	Positive (%)	Neutral (%)	Negative (%)	No. of respondents
Clinical Support	61.5	18.3	20.2	109
Community	54.2	31	14.8	142
Corporate services	54.9	20.6	24.6	175
Estates and Facilities	65.4	23.1	11.5	52
Medical	54.3	28.4	17.3	81
Surgical	59.4	30.4	10.1	69
Woman and Children	62.9	20	17.1	35
Prefer not to say	64.2	18.9	17	53

2.2. West Suffolk Alliance, Norfolk & Suffolk ICB, and NHS Essex ICB (ATTACHED)

Presented by Maddie Baker -Woods

Meeting/committee title: WSFT Board, October 2026

Report information

Report title: Norfolk and Suffolk ICB End of Life Care Investment: Target Outcomes

Agenda item:

Sponsor/Executive lead: Maddie Baker-Woods – Suffolk Primary Care and Neighbourhood Director

Report prepared by: Helen Tunster, Senior Commissioning Lead

Previously considered by:

This report is for: ☐ Approval ☐ Assurance ☐ Discussion ☒ Information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What?

The ICB is making recurrent investment in an integrated palliative and end of life pathway. In West Suffolk, which supports earlier identification and advance care planning through primary care, Hospice Neighbours and the My Care Choices Register (MCCR); expanded specialist Hospice at Home services and verification of expected death training; together with six additional inpatient beds at St Nicholas Hospice.

So what?

The pathway is intended to identify people earlier, make their wishes visible across services and provide responsive alternatives to hospital, where appropriate. It should enable more people to die in their chosen place, including at home, while, as appropriate, reducing ambulance conveyance, emergency admission, acute bed days, delayed discharges and hospital deaths.

What next?

WSFT is asked to support the roll out and implementation of MCCR across acute and community settings and embed referral and escalation routes to Hospice at Home or St Nicholas Hospice. Delivery will be monitored through provider returns and the ICB end of life dashboard.

Action required by the board:

To note the intended outcomes and support WSFT operational participation in the delivery of the business case.

Governance and compliance

Risk and assurance: The financial model is scenario-based and does not yet enable overlap between schemes to be wholly assessed. Assurance depends on linked patient-level activity, agreed

comparator groups and time required to enable delivery of benefits for patients, their families, carers and staff.

Equality, diversity and inclusion: Evaluation will assess access and outcomes through a Core20PLUS5 lens, and groups currently experiencing inequity.

Sustainability: Sustainability Impact Assessments are in place for all newly commissioned services and transformation workstreams – governance is held in the ICB.

Legal and regulatory context: Governance is held within the ICB. This report is for information to the Trust.

End of Life Care Investment: Target Outcomes

1. Introduction

- 1.1. This paper outlines the outcomes expected from the Norfolk and Suffolk ICB Suffolk End of Life Business Case for West Suffolk, approved by the ICB in May 2026. It focuses on how the three funded schemes will work together to support choice, particularly care and death at home where this is the person's preference, and how they are expected to reduce avoidable hospital use.

2. Background

- 2.1. Suffolk faces growing need for end of life care as deaths are projected to increase by 22% between 2018 and 2030, exceeding overall population growth. Without appropriate services, non-elective hospital admissions for people in the last 90 days of life are forecast to rise by 14% by 2030/31.
- 2.2. Current services are not consistently meeting people's needs. Across Suffolk, only 0.45% of the population are identified as being in their last year of life, against a national expected level of 1%. This is the first important step to enabling advance care planning and coordinated care. Evidence from the My Care Choices Register (MCCR) programme in North East Essex shows that people with a recorded care plan are half as likely to die in hospital and around 80% achieve their preferred place of care, demonstrating the benefits of earlier identification and proactive support.
- 2.3. The proposed investment will strengthen an integrated end of life care model by expanding early identification, advance care planning, and provision of specialist palliative and end of life care at home (Hospice at Home) and inpatient care at the Hospice. This will improve patient choice, reduce inequalities, support more people to remain in their preferred place of care and shift care from hospital to community settings.

3. Detailed sections and key issues

- 3.1. The three schemes of the business case are as follows:

Earlier identification and care planning

GP enhanced scheme, Hospice Neighbours and MCCR will identify people earlier, support compassionate conversations and make preferences visible to relevant services, enabling coordinated decisions before a crisis.

Specialist care at home

Expanded Hospice at Home and verification of expected death training will provide rapid specialist advice, symptom control and practical care, helping families sustain care at home and avoiding ambulance conveyance or admission, if appropriate.

Alternative to acute hospital

Sustaining six additional specialist inpatient beds at St Nicholas Hospice enables step-up from the community and timely transfer from hospital, when home is not achievable.

3.2. Benefits and outcomes over the investment period

Qualitative benefits include greater choice, dignity and confidence for patients and carers; improved symptom control; fewer crises; better coordination and responsiveness; and more equitable access.

Quantitative outcomes include identification of 1% of people at the last 12 months of life; 90% of people identified have wishes recorded on MCCR; at least 80% of people with wishes recorded dying in their preferred place and agreed service activity and occupancy measures for the Hospice beds with reductions in non-elective admissions and bed days.

During 2025/26 the ICB commissioned St Nicholas hospice to increase hospice beds from 6 to 12 and to introduce out of hours rapid response service for part of the week with Better Care Funding, on an agreed interim basis. The qualitative feedback from patients, family and staff has been highly supportive of these changes. The recent ICB review of specialist palliative and end of life care included a quantitative analysis of admissions and occupied bed days for people in the last 12 months of life over the last three years.

WSFT	23/24	24/25	25/26 FOT M10	25/26 FOT vs 2024/25	
Bed days	46,732	49,753	44,854	- 4,899	-10%
Admissions	4,422	4,747	4,545	-202	-4%
Average length of stay	10.6	10.5	9.9	-0.6	-6%

This shows reducing admissions, bed days and length of stay in West Suffolk during 2025/26 from the point of the above investments. It is likely that increasingly strong professional relationships between hospital, community and hospice teams and the availability of additional beds and specialist community services have supported people to remain at home or to be discharged from Hospital to the Hospice. This is in the context of an estimated annual increase in palliative care need of 2.4% per annum.

In 2026/27 we expect to see the benefit of a **full year effect** of the six additional beds and the ICB commissioned out of hours rapid response service coverage for the **whole week**. The ICB estimates that these changes will enable the additional palliative care demand to be managed in an out of hospital setting and offers good value for money in terms of comparative cost of meeting this growth in hospital.

3.3. Key issues

The delivery depends on successful uptake and use of MCCR by staff and patients, and visibility of records across the system. The delivery of an integrated end of life pathway depends on workforce, referral behaviour, service integration and sustainable uptake. Strong assurance will require West Suffolk-specific baselines, agreed service trajectories, hospice-to-ICB data flows, reporting ownership and transparent realisation of benefits.

4. Next steps

The next steps are to:

- 4.1. Continue to implement and to monitor the benefits of the three schemes in the business case, to include launch of MCCR in WSFT (community and acute) supported by the End of Life Care Operational Group and further strengthening integration with St Nicholas Hospice.
- 4.2. Finalise the full evaluation plan, set up the mechanisms to monitor the activity and evaluation metrics, monitor and evaluate the impact on preferred place of death, hospital admissions, bed days, inequalities and patient/carer experience.

5. Conclusion

The forward plan and investment creates a coherent pathway from earlier identification and shared planning to specialist support at home and hospice inpatient care. If implemented as an integrated system offer, it should improve choice and experience, enable more people to die at home or in another preferred place, and reduce avoidable use of acute hospital services. It is anticipated that the business case will be evaluated at 1 year.

6. Recommendations

The Board is asked to note the intended outcomes and value for money assessment, and to support WSFT operational participation in the delivery of the business case.

3. HIGH QUALITY CARE

3.1. Integrated Quality & Performance Report (IQPR) (ATTACHED)

To Assure

Presented by Jude Chin

Integrated quality and performance report (IQPR)

July 2026

Compassionate care,
healthier communities

Executive summary:

This report is for **Assurance**.

This reports supports the following ambitions within the organisational strategy:

- High quality care
- Joined up services
- Empowered to improve
- Responsible with resources
- Fit for tomorrow

What?

The purpose of this report is to provide information and analysis relating to key performance indicators for quality, safety, operational standards and workforce during May 2026. This enables Trust Board to scrutinise performance and engage in an assurance process which supports continuous improvement and learning. The performance metrics are allocated to assurance committees as part of this process.

So what?

The Integrated Quality and Performance Report (IQPR) uses the Making Data Count (MDC) methodology to report on the following aspects of key indicators:

1. The ability to reliably meet targets and standards (pass/fail)
2. Statistically significant improvement or worsening of performance over time.

Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). An explanation of MDC is available in the appendices.

What next?

The narrative alongside the data summarises the actions being taken to improve performance where this is not meeting standards and/or is worsening over time.

Executive lead: Daniel Spooner, chief nurse. Nicola Cottington, chief operating officer and deputy chief executive and Julie Hull, chief people officer

Report prepared by: Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.



Delivering compassionate care and healthier communities

Our performance highlights- July 2026

ED 4 hour performance

69.4%

of patients admitted,
transferred or discharged
within four hours of arrival (July)
On track for March 27 target of 82%



Elective RTT

65.6%

18-week referral to
treatment performance
(July)
Working towards 70% target for March 27



Cancer targets

28-day Faster
Diagnosis Standard
(June)

80.7%

hitting the standard

62-day referral to
treatment (June)

65.6%

hitting the standard

Financial performance

At month four (July), we
finished with a:

£2.1 million deficit

Above plan but not unexpected due
to reduced ability for activity



Q4 Pulse Survey (April)

Engagement

6.47 up from 6.18

Advocacy

6.27 up from 6.18

Motivation

6.71 up from 6.40

Involvement

6.44 up from 6.26

Diagnostics

80.9%

Patients receiving
diagnostic test within
six-weeks (July)



Assurance – can the target be consistently achieved?				
July 2026	Consistently hitting target - celebrate 	Target not consistently achieved or failed 	Consistently fail target - investigate 	No target set – celebrate , monitor or investigate
Special cause improvement- celebrate  		F&P 28 Day Faster Diagnosis	F&P Diagnostics Performance % within 6weeks Total RTT 65+ Week Waits Q&PS Patient Safety Incidents	F&P RTT 52+ Week Waits RTT 52+ Weeks Wait as % of Total WL RTT <18 Week Waits (% All) RTT <18 Week Waits (% First OPA) Q&PS Incidents Reported
Common cause – monitor & understand 	F&P Urgent 2 hour response - UCR POD Staff Sickness – Rolling 12months Staff Sickness	F&P Non-admitted 4 hour performance Virtual Ward Total average occupancy percentage POD Mandatory Training Turnover	F&P Ambulance Handover within 15min Incomplete 104 Day Waits	F&P 12 Hour Breaches 12 hour breaches as a percentage of Type 1 attendances RTT Waiting List Q&PS INT Nursing Deferred by Service Inpatient Deaths Formal Complaints Received Formal complaints resolved late (>25wd) PALS Received
Special cause concerns - investigate  		F&P Cancer 62 Days Performance	POD Appraisal	F&P Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 52 Weeks Wait Q&PS SHMI

National oversight framework (NOF)

NHS Oversight Framework - Acute trusts

Current data: Q4 2025-26
Published: 11 June 2026


[About](#)
[Overview](#)
[League table](#)
[Metrics table](#)
[Trust map](#)
[Trust chart](#)
[Timeseries table](#)
[Timeseries chart](#)
[Statistics table](#)
[Metric metadata](#)
[Glossary](#)

Select a trust

West Suffolk NHS Foundation Trust (RGR)

[View the glossary page](#)

Average score

2.30

Lower by 0.09 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics). Scores range from 1.00 (high performing) to 4.00 (low performing).

[How has average score been calculated?](#)

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

[How is financial deficit applied?](#)

Segment

3 - Below average and/or financial deficit

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

[How has segment been calculated?](#)

Trust rank

66 out of 134

Previous quarter's rank: 68 out of 134

Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).

[How has rank been calculated?](#)

Performance domains ?

Access to services

2 - Above average



Finance and productivity

3 - Below average



Effectiveness and experience

2 - Above average



Patient safety

4 - Low performing



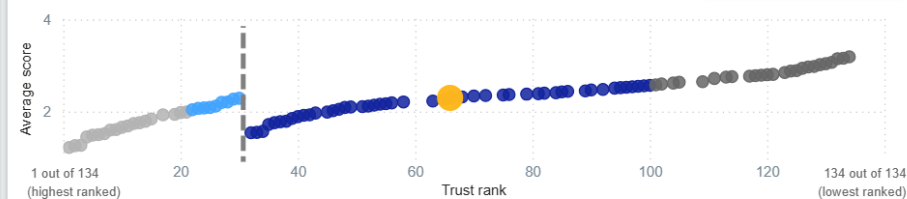
People and workforce

3 - Below average



Average score by trust rank placement

Segment 1 2 3 4 Selected trust


[View full league table](#)

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What?

- The National Oversight Framework (NOF) score for WSFT is 66 out of 134 Trusts for quarter 4 of 2025/26. The previous rank was 68. The segment remains unchanged at 3.

So what?

- The NOF is a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

What next?

- NOF domains are reflected in other metrics so we can monitor changes and improvements. Financial recovery continues, in order that the financial override can be overcome once the Trust is in financial balance.

Health inequalities – ED 12-hour breaches

What?

- July 2026 saw 8,640 Type 1 patients depart ED at West Suffolk. 813 of those patients were in ED for 12 hours or more – 9.41% of all Type 1 departures. This is higher than the average for 2025/26 overall, when 6.96% of Type 1 patients spent over 12 hours in ED but is an improvement on what was seen in 2024/25 with an average of 10.36% of all Type 1 patients spending more than 12 hours in ED
- 49.82% of patients who experienced a stay in ED of 12 hours or more in July 2026 were female, 50.18% were male and 0% were unspecified. Trust level data shows that in 2025/26 54.59% of patients who accessed acute services at WSFT were female, 45.36% were male and 0.05% were unspecified
- 65.87% of patients who experienced a stay in ED of 12 hours or more were over 75 years old. The next highest group was of patients aged 61 to 75 years old (27.40%)
- 89.17% of patients who experienced a stay in ED of 12 hours or more were white (British, Irish or other). Data from the 2021 census stated that 83.89% of Suffolk residents were white
- Trust level demographic data is based on inpatient admissions and outpatient and emergency department attendances in 2025/26 at West Suffolk

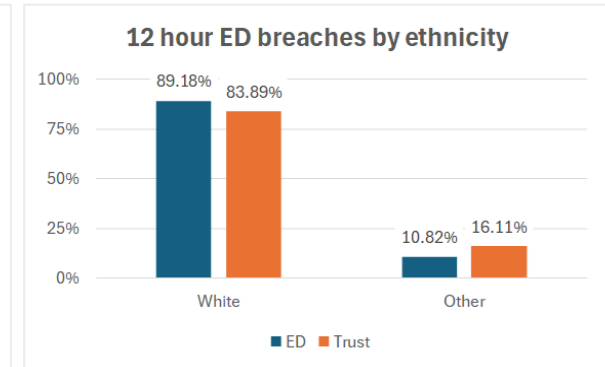
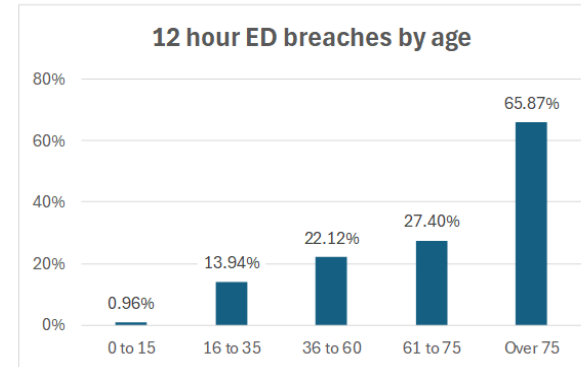
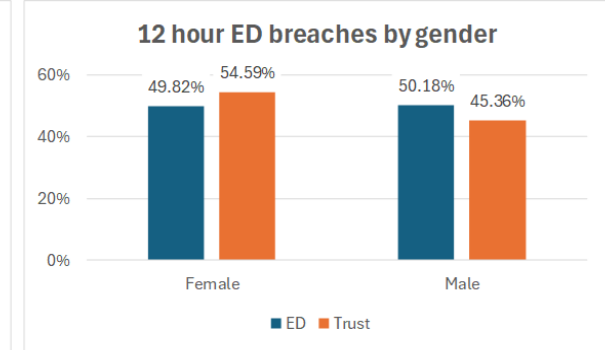
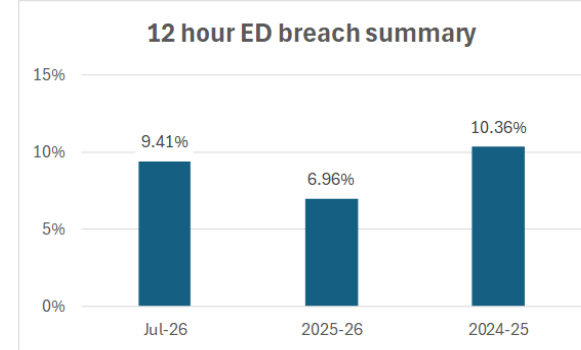
So what?

Reporting on health inequalities helps us understand potential areas for improving access and waiting times and ensuring the care we provide is equitable and fair.

What next?

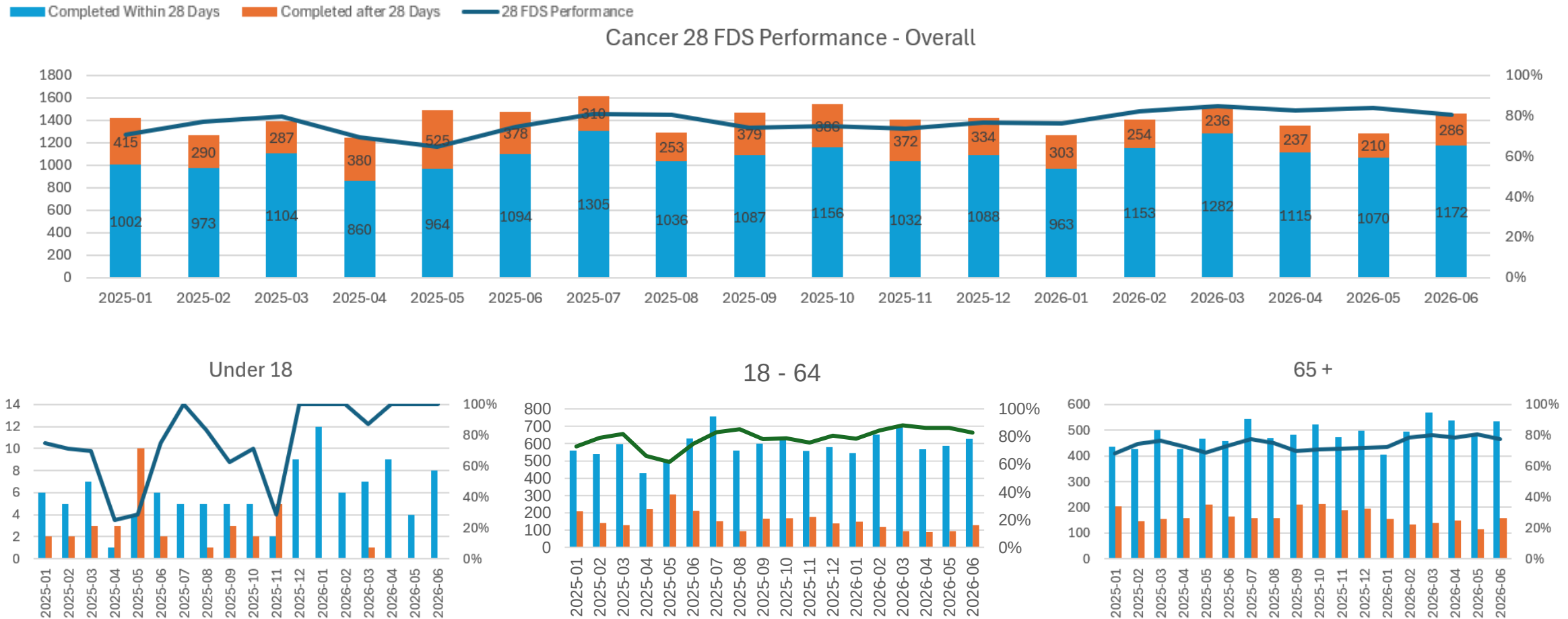
These data demonstrate that most long waits in ED are experienced by people over 75 years, and that there appears to be a disparity between ethnic groups, although ethnicity is not stated for 5.45%. We know that long waits in ED cause harm and it is critical that understand the drivers of inequalities, and that we design and deliver services that better care for older people, including avoiding ED attendance wherever possible.

Additional reporting is being built for the Referral to Treatment (RTT) total waiting list. The Executive Team are reviewing the strategic approach to investigating and addressing health inequalities.



White - British	668	82.16%	Asian - Any Other Asian Background	2	0.30%
Other - Not Stated	77	9.47%	Asian or Asian British - Bangladeshi	1	0.15%
White - Any Other White Background	57	7.01%	Black or Black British - Caribbean	1	0.15%
Black - Any Other Black Background	3	0.37%	Other - Chinese	1	0.15%
Other - Any Other Ethnic Group	3	0.37%			

Health inequalities – 28 days FDS performance by age group

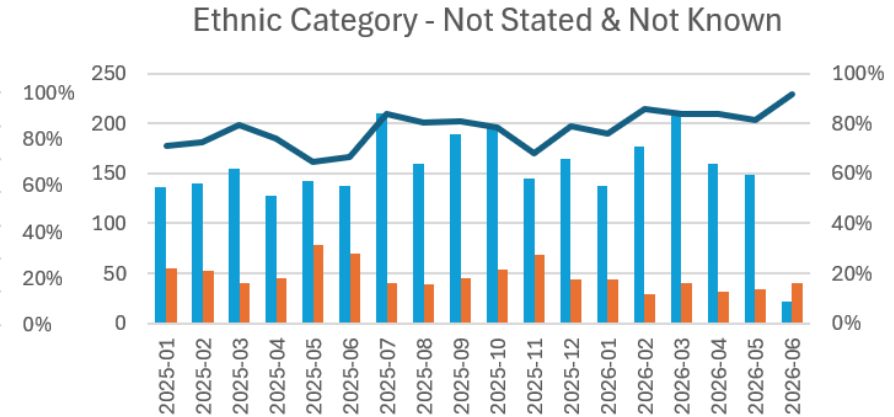
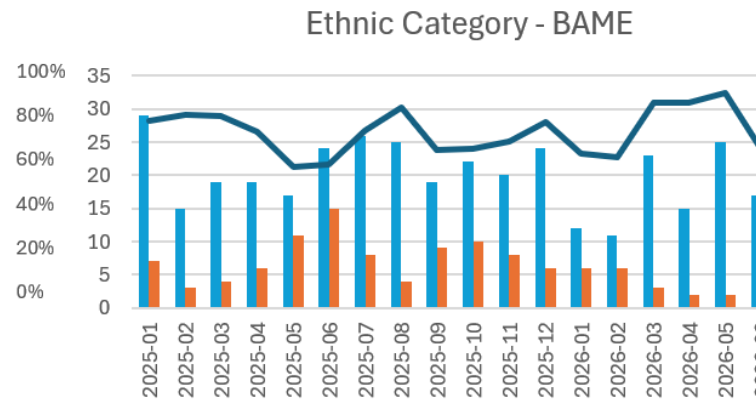
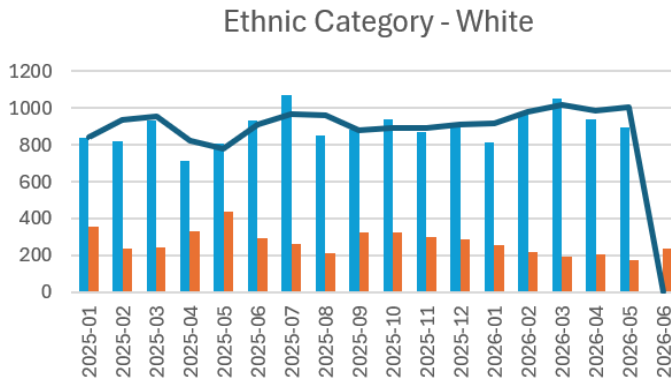


What?

- Under 18: Performance varies due to low volumes but improves sharply, meeting or exceeding the 75% target by year-end.
- 18 - 64: Consistently strong, staying at or above the 75% target for most of the period.
- 65 +: Falls below target mid-year but steadily improves, finishing close to the 75% benchmark.
- Overall: Differences in performance across age groups are primarily due to pathway complexity (older patients) and external provider dependencies (Under 18), not unequal access. The system performs broadly around the 75% target once these age-specific factors are accounted for.

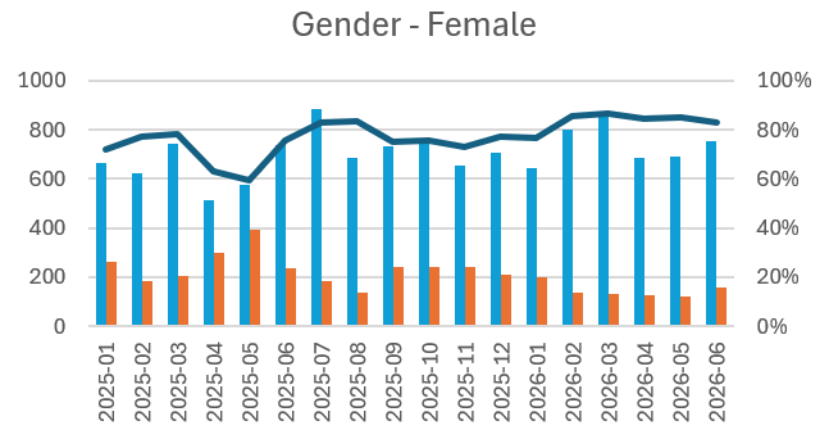
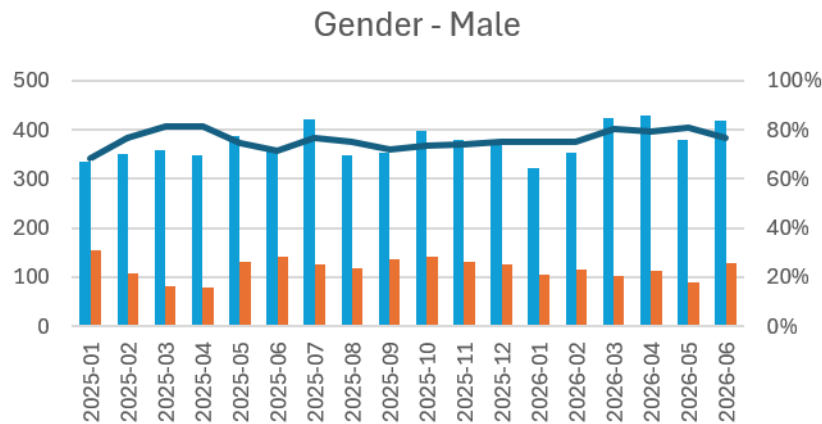
Health inequalities – 28 days FDS performance by ethnicity and gender

Completed Within 28 Days Completed after 28 Days 28 FDS Performance



Performance across groups sits around the 75% target; month-to-month dips align with operational factors (case-mix, capacity, coordination).

Focus actions on faster booking, shared diagnostic slots for cross-site referrals, proactive management of complex pathways and improved ethnicity recording.



Both male and female groups track close to the 75% target, with similar mid-year dips that align with wider system pressures, not differences in access. Unfortunately, data volumes were too low to publicly report performance for genders outside male and female. This limits interpretation but does not indicate poorer access.

Finance and Performance committee metrics

Compassionate care,
healthier communities

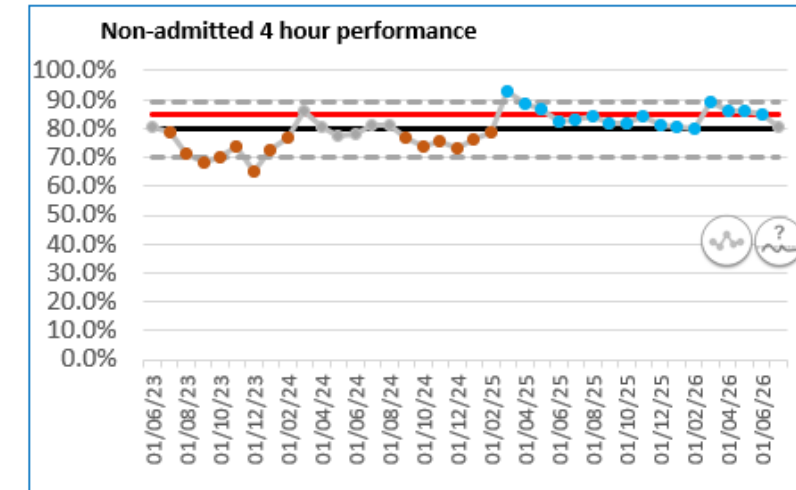
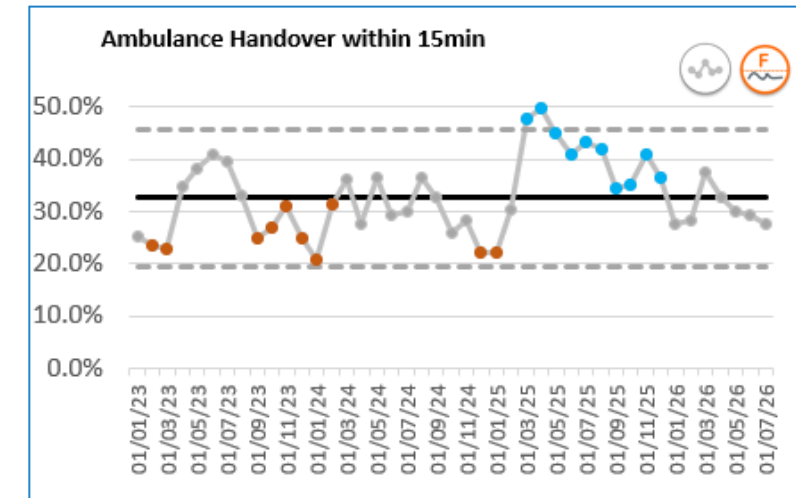
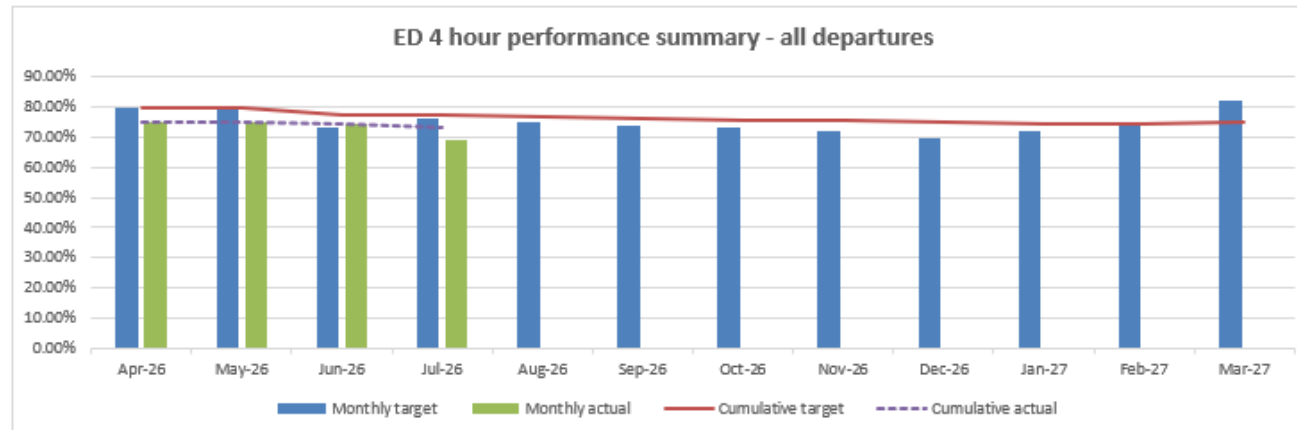
Urgent & Emergency Care: ambulance and 4-hour performance

What?

- In July, no significant change was demonstrated in the ambulance handover within 15mins metric. 27.52% of our ambulance handovers were achieved within 15 minutes, against a target of 65%.
- July's non-admitted 4-hour performance was 80.83%, which means we did not achieve our internal target of 85%.
- Overall 4-hour ED performance for July was 69.39%, meaning we failed to meet the monthly trajectory of 76%.

So what?

- Meeting the Urgent and Emergency Care (UEC) performance metrics means that our patients received timely, safe care.
- Meeting the in-month trajectory for the 4-hour Emergency Department metric will keep us on track to achieve 82% by March 2027.
- What next?**
- Weekly performance meetings with the ED Tri and divisional TRI, Senior Leaders/Executives and some specialities.
- Focus on the use of EDSDEC (ED Same Day Emergency Care), particularly out of hours, Band 6 nurse pilot for 3 months planned to encourage this.
- FRAT (Front Door Rapid Assessment and Triage) – relaunched model with increased consultant input. FRAT consultant can now stream direct to EDSDEC following review if appropriate. Continues.
- Continued focus on all SDEC pathways.
- Working through focussed streams, identified in the UEC Delivery Group.
- Focus on recruitment – Consultants and Registrars, with limited agency registrars whilst this happens.



Urgent & Emergency Care: ED 12-hour performance

What?

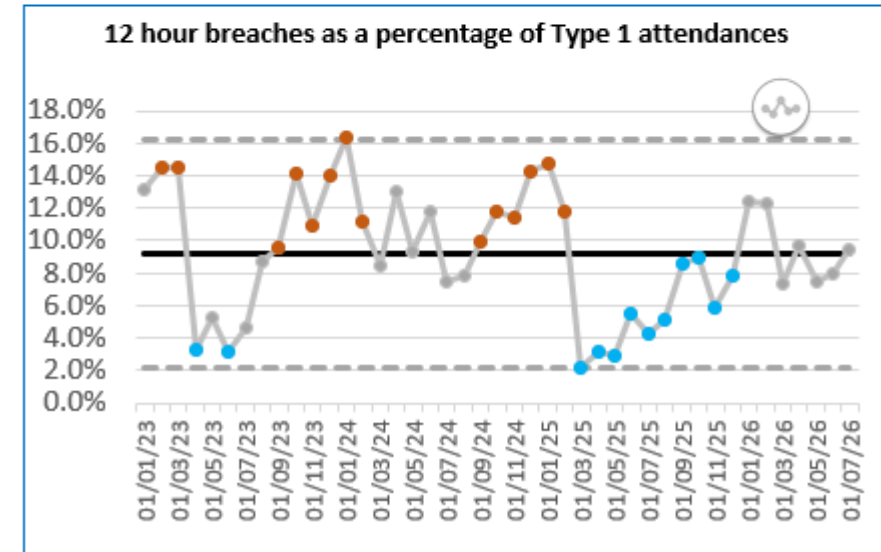
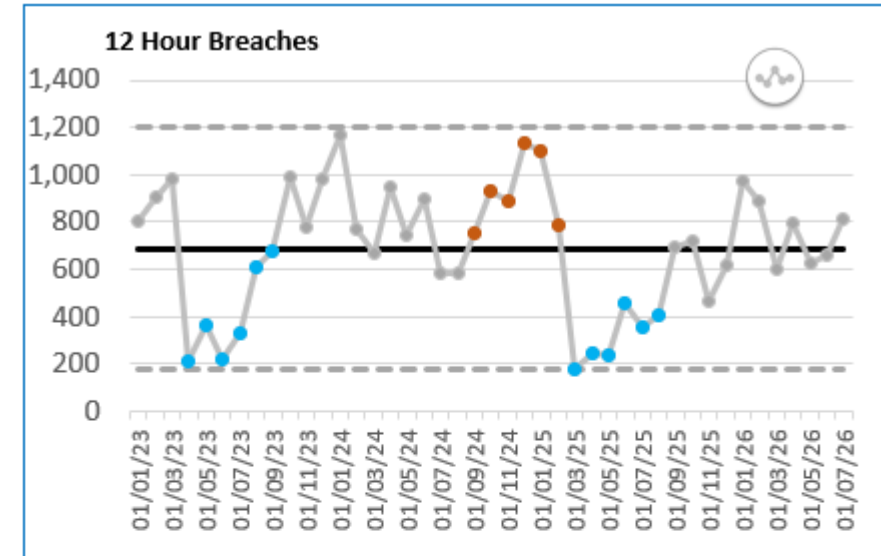
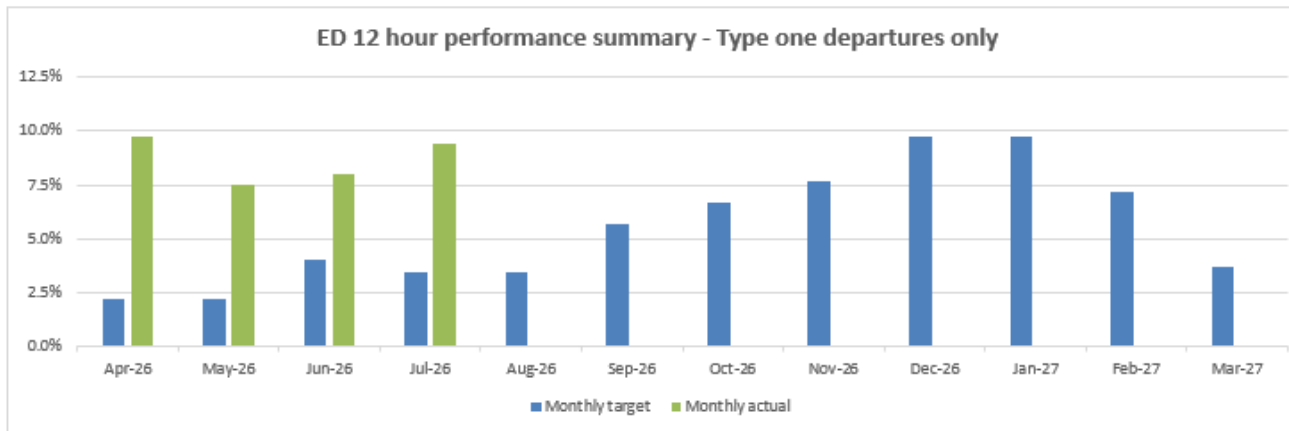
- The number of 12-hour length of stay breaches in July was 813.
- 7.49% of all Emergency Department (ED) attendances were 12-hour breaches.

So what?

- 9.4% of patients attending ED spent more than 12 hours in the department, which is a poor patient experience.
- We did not meet our monthly trajectory of 3.5% for 12-hour LOS in ED
- The impact of more 12 hours breaches in the ED is that temporary escalation spaces were regularly used, including Rapid Assessment Triage (RAT) and Same Day Emergency Care, both of which impact on our ability to offload ambulances and the flow in and through the department. At times, the RAT corridor was also used to support ambulance offloads.

What next?

- Continued focus on length of stay (LOS) reductions to support flow out of ED including the ongoing task and finish group for board rounds/huddles.
- Focus on right patients being placed in correct speciality, supporting specialist needs & LOS reductions.
- Working with Transformation team to process map patient discharge pathway within clinical wards to highlight any themes that are delaying discharges with aim to bring on day discharge times earlier.
- Project for criteria led discharge in planning stage – external funding has been agreed.



Urgent & Emergency Care: Urgent Community Response (UCR)

What?

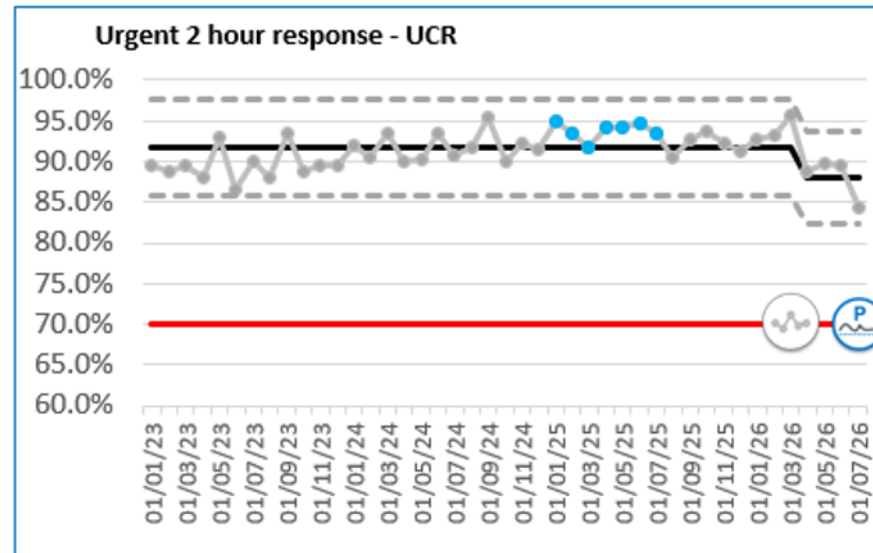
- UCR is above target overall. Nursing in the Integrated Neighbourhood Teams (INTs) is just below target because of sustained pressures of rising demand whilst ongoing recruitment is in progress.

So what?

- Whilst the performance is above target there is an impact on patient safety, as increased deferrals, or cancellations of visits in community nursing teams presents risk to quality of patient care and impacts on staff well-being.

What next?

- Investment in community nursing agreed, vacancies are being recruited to. The model of shared service delivery (SSD) continues to bring efficiencies in service delivery.
- Number of deferred or cancelled visits and harm audit are monitored.
- Workforce review, utilising community Nursing Safer Staffing Tool (CNSST) completed, next step is professional input into tool, followed by triangulation in September.
- Project to reduce high sickness levels continues.



Urgent & Emergency Care: virtual ward

What?

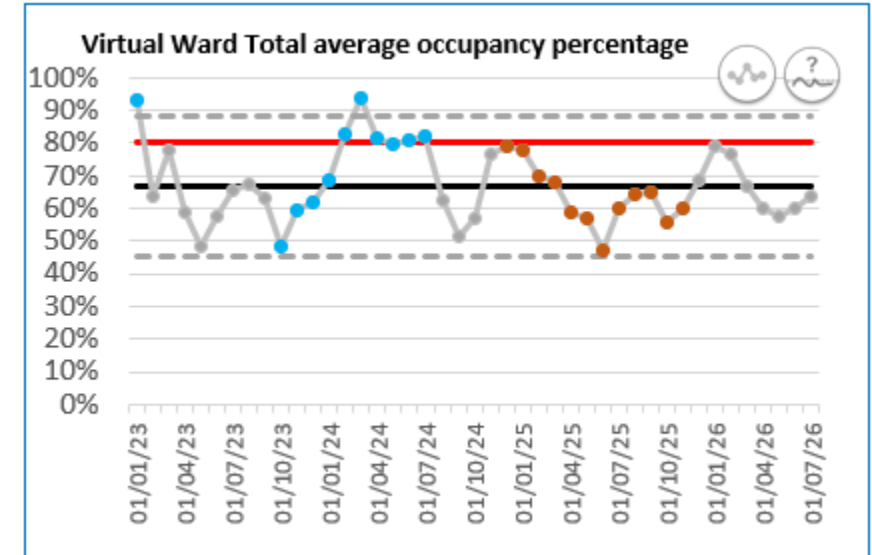
Average occupancy is below target. The individual pathways fluctuate in occupancy, contributing to overall low utilisation.

So what?

Virtual ward capacity is critical in ensuring patient flow across the Trust and ensuring the strategic ambition of caring for patients at home whenever possible.

What next?

- Virtual ward Consultant post is vacant, temporary cover continues.
- Work ongoing to increase utilisation of respiratory pathway, currently awaiting feedback from Medicine Division on way forward.
- Step up pathway to general medicine and antimicrobial pathways in process of sign off by governance groups to facilitate Advanced Care Practitioner (ACP) autonomy and increased step up onboarding.
- Integrated IV pathway to be implemented from 1 September following work with outpatient antibiotic team
- Review of service model towards Shared Service Delivery planned to commence in late September including relocation of VW team into locality bases, whilst maintaining presence and relationships in hospital. ACPs will work across virtual and urgent pathways in the community and provide escalation/senior clinical oversight for INTs, enabling increased step up activity.



Cancer access

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jun 26	80.7%	77.0%			71.5%	59.4%	83.5%
Cancer 62 Days Performance	Jun 26	76.0%	70.0%			74.4%	60.0%	88.8%
Incomplete 104 Day Waits	Jun 26	10	0			22	0	44

What?

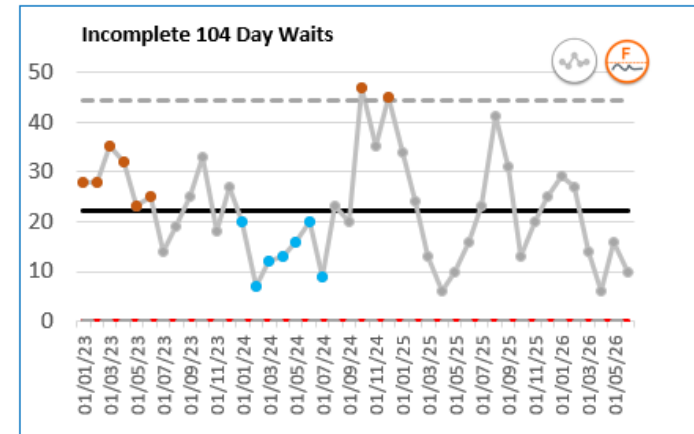
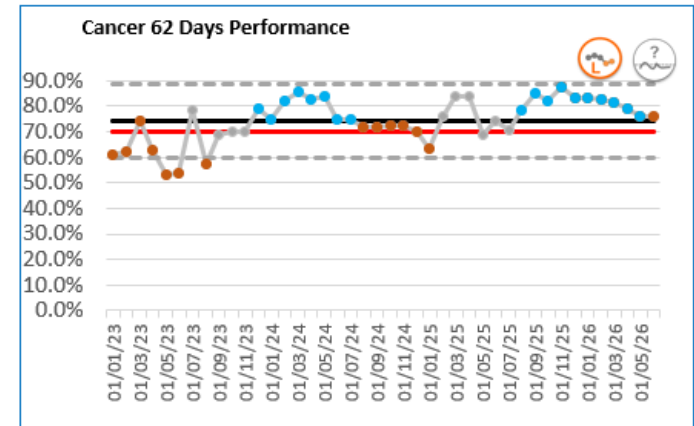
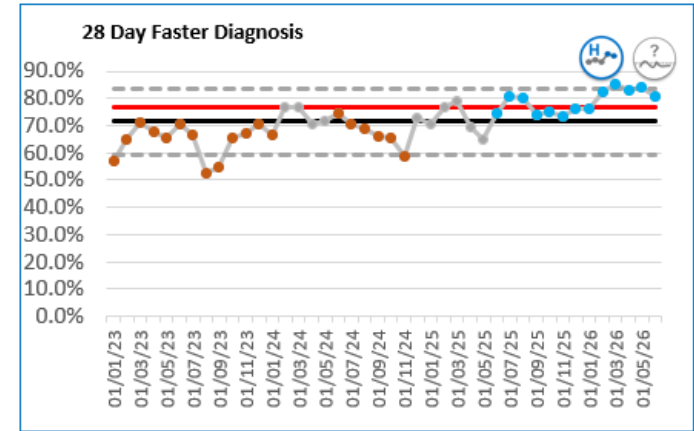
- 28 day performance was 80.7% in June, which is above trajectory and overachieving against the 80% requirement.
- Urology performance remains challenged and under trajectory whilst Breast has recovered due to the insourcing of first clinic appointments.
- Performance in Head and Neck, Skin, Gynaecology, Lung and Upper GI have been consistent throughout the year.
- 62-day performance has dropped slightly, due to pathway challenges in Urology and Breast but remains above target overall.

So what?

- The priorities for 2026/27 this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.

What next?

- Breast insourcing for first appointment will continue throughout 2026/27.
- Nurse led template biopsy training is now complete and independent lists will commence in Q3.
- Additional theatre activity in place for Breast throughout July to allow return to trajectory from August for 62-day performance
- Continued engagement with Cancer Alliance led Breast services review.
- Contracting agreements for the community skin pathway to be resolved, and agreement needed on the future of the pathway.



Diagnostic performance

What?

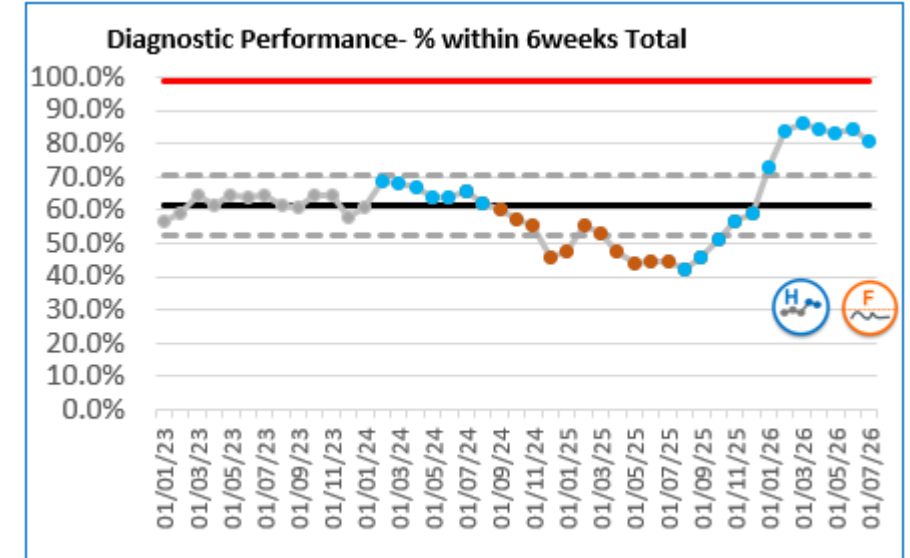
- The monthly Diagnostics Waiting Times and Activity Data (DM01) measures the number of patients waiting six weeks or more for 15 key diagnostic tests.
- WSFT is behind the agreed recovery trajectory of 85.90%, with 80.88% of patients in July receiving their tests within six weeks.
- The principal areas of non-compliance are endoscopy, ultrasound and audiology.

So what?

- Longer waiting times for diagnosis and treatment have a detrimental effect on patients.
- Delay in achieving DM01 compliance standards and Referral to Treatment (RTT) standards.
- Reputational harm and lack of confidence in our services for our patients.

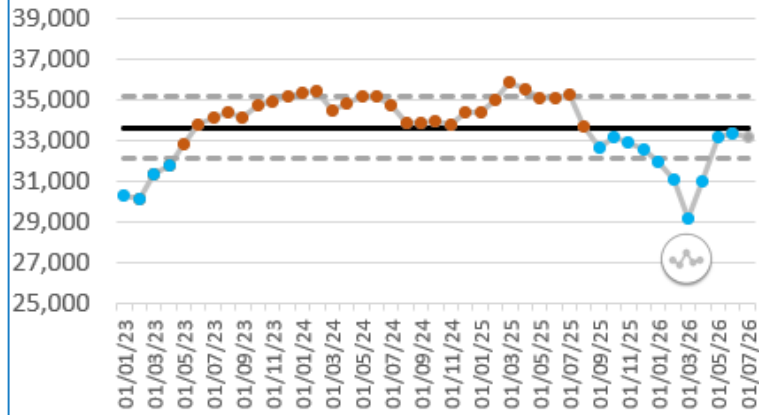
What next?

- Insourcing of Ultrasound activity to commence 22nd August
- Data quality review of Audiology patients
- Insourced endoscopy activity to take place in-week in addition to the weekends
- Recovery actions forecast improvement to 88% in March 2027 in line with the agreed plan for DM01 performance.

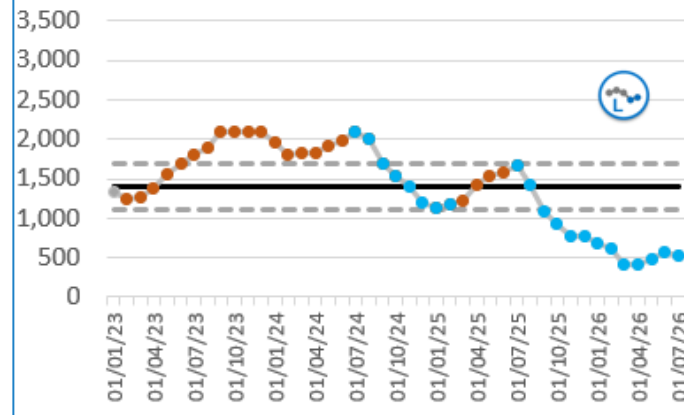


Referral to treatment (RTT) performance

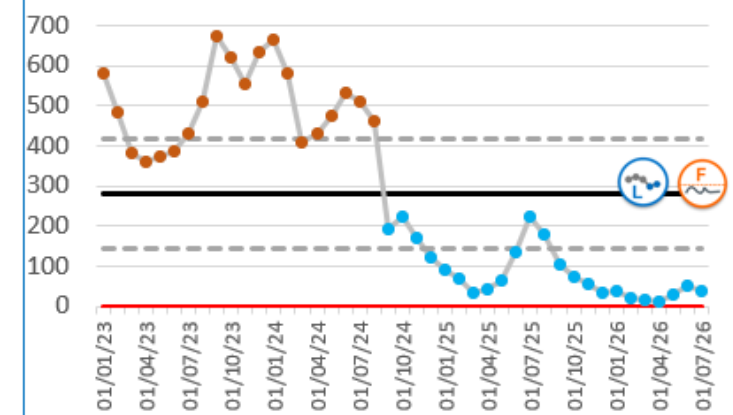
RTT Waiting List



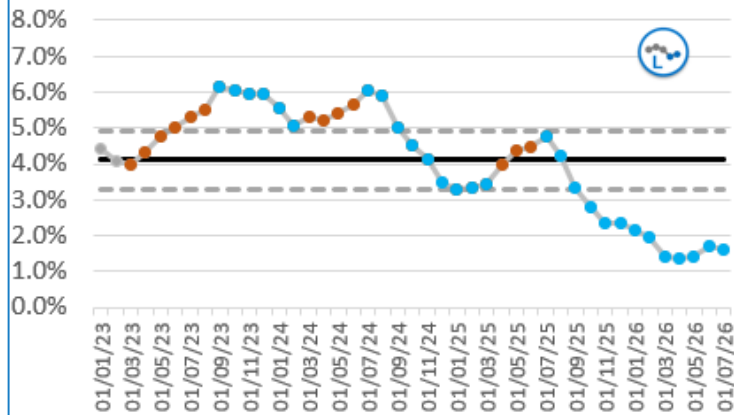
RTT 52+ Week Waits



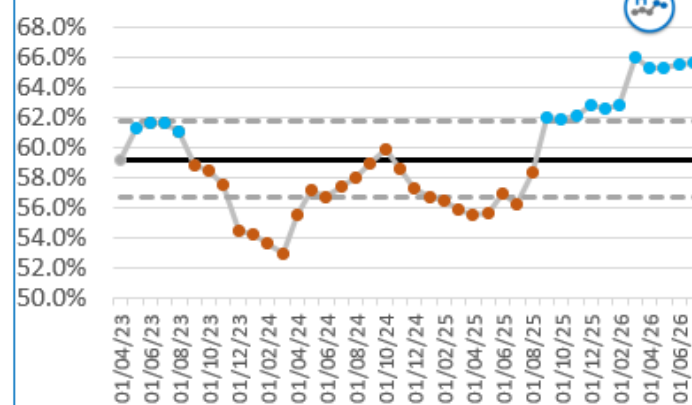
RTT 65+ Week Waits



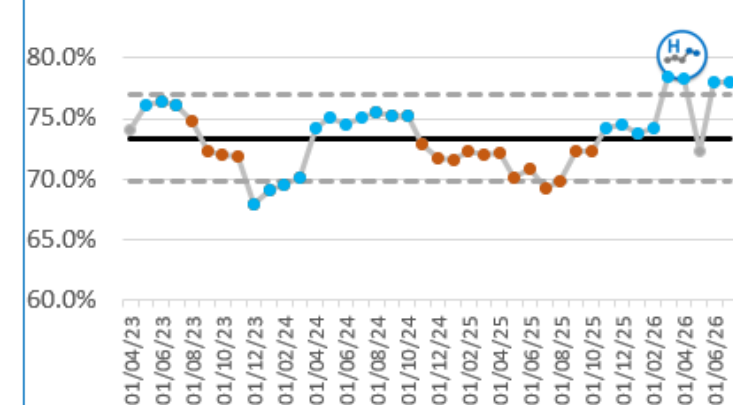
RTT 52+ Weeks Wait as % of Total WL



RTT <18 Week Waits (% All)



RTT <18 Week Waits (% First OPA)



Referral to treatment (RTT) performance

Overall 18-week
compliance
July 2026

65.7%

Patients with
65 week wait
July 2026

36

Patients with
52 week wait
July 2026

533

Total waiting list

33152

% of patients being seen
for first OPA within 18
weeks

78.0%

What?

- Overall RTT compliance was at 65.7%, which is marginally above the July 2026 forecast of 65.32%, this was supported by additional data quality validation.
- The volume of patients waiting 65 weeks increased, partly due to on-going closures of Orthopaedic theatres and on-going capacity constraints in Gynaecology. The volume of patients over 52 weeks is higher than trajectory slightly reduced from the June position, however this remains significantly above plan.
- The areas with the highest cohort of 52 weeks are Gynaecology, Orthopaedics and Vascular.
- The total waiting list size reduced slightly in July, but remains above plan.

So what?

- Patients are at increased risk of harm and/or deteriorating the longer they wait. This increases the demand on primary and urgent and emergency care services as patients seek help for their condition.

What next?

- Delivery against 2026/27 activity schemes, which will be monitored via the Elective Delivery Board.
- External validation resource to continue whilst internal recruitment is underway.
- Insourcing of Vascular activity expected to commence in September 2026.
- Return of Orthopaedic theatres due 20th July 2026.

Community paediatrics

What?

- There is sustained deterioration in waiting times for the paediatric team due to ongoing level of demand above the available capacity within the medical team.
- Longest waiting times, above 52 weeks, are primarily associated with autism assessments although average waiting times for preschool assessments are also increasing.

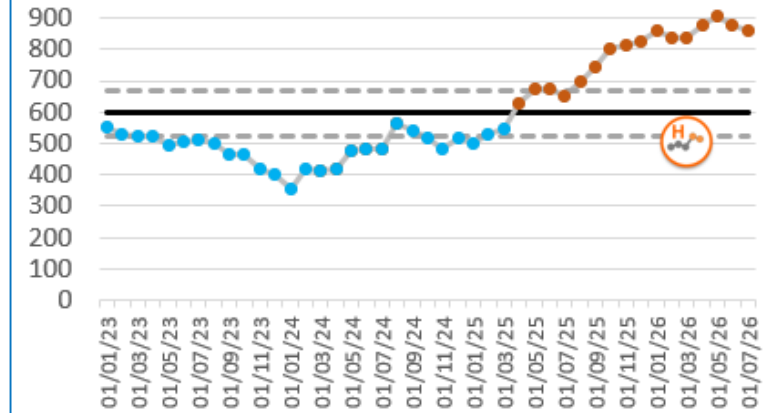
So what?

- Children are waiting longer for autism assessments in the school age pathway.
- There are increasing waiting times in preschool pathway as the service responds to high demand alongside the requirement to manage children with complex care needs/reviews and prioritise clinician time.

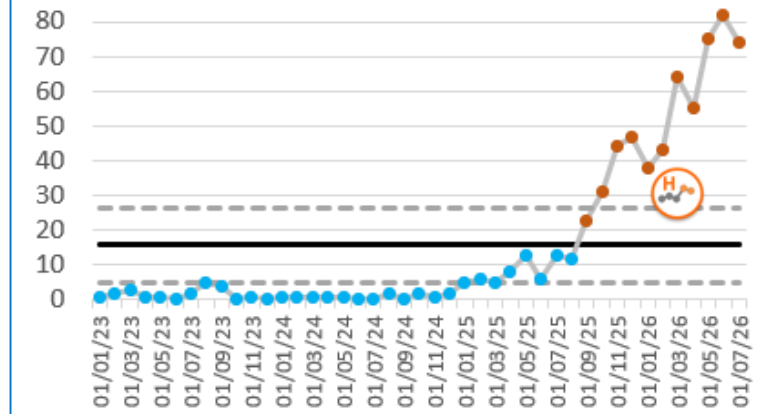
What next?

- ICB-led recommissioning of neurodevelopmental diagnostic assessment pathway. Implementation of new pathway scheduled to be April 2027
- Full time consultant vacancy covered by agency locum consultant (full time hours not covered) within the east team – substantive appointment made with start date in September.
- Monthly monitoring of long waits continues.
- Outsourcing of autism assessments for longest waiters is progressing well.

Community Paediatrics RTT Overall Waiting List



Community Paediatrics RTT Overall 52 Weeks Wait



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Community Paediatrics RTT Overall Waiting List	Jul 26	862				597	526	669
Community Paediatrics RTT Overall 52 Weeks Wait	Jul 26	74				16	5	26

Elective activity plans

What?

- First outpatient attendances are slightly behind plan, with greatest variance seen in May.
- The deficit in elective activity is significant; this is due to the continuation of overrunning refurbishment works in main theatres which concluded on 20 July 2026, as well as low benchmarked theatre utilisation.
- Day case activity was not affected by the refurbishment works although is behind plan, with the June and July deficit recovering from the May position.
- Outpatient follow ups are above plan, whereas they need to be at or below this level, however July did see this trend reversed.

So what?

Delivery of our activity plan is required to meet both financial and operational performance objectives in response to the NHS Medium Term Plan, with further activity required that has been identified as part of the 2026/27 Cost Improvement Plan.

What next?

- Specialty level RTT trajectories are monitored through weekly access meetings.
- The Elective Delivery Board oversees specialty level recovery plans which identify when and where additional activity will take place to recover the running deficit.
- Workstreams across theatres, outpatients, diagnostics, clinical coding and system-wide initiatives will drive delivery of these.

Outpatient First

	Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr		9,664	9,449	9,830	(166)	(1.7%)
May		9,336	9,332	9,713	(377)	(3.9%)
Jun		11,142	10,631	11,252	(110)	(1.0%)
Jul		11,033	10,631	11,262	(229)	(2.0%)
Aug			8,855	9,591		
Sep			10,393	11,279		
Oct			10,156	11,094		
Nov			10,156	11,094		
Dec			10,160	11,133		
Jan			9,446	10,419		
Feb			9,571	10,544		
Mar			9,805	10,778		
Total (YTD)		41,175	40,043	42,057	(882)	(2.1%)

July 2026

26/27	11,033
Plan (B)	10,631
Plan (T)	11,262
Var	(229)
Var %	(2.0%)

Outpatient Follow Up

	Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr		26,546	24,251	24,569	1,977	8.0%
May		25,304	23,954	24,272	1,032	4.3%
Jun		28,618	26,682	27,035	1,583	5.9%
Jul		26,884	27,284	27,665	(781)	(2.8%)
Aug			22,732	23,113		
Sep			26,682	27,091		
Oct			26,069	26,531		
Nov			26,074	26,536		
Dec			24,248	24,724		
Jan			24,556	25,032		
Feb			25,168	25,644		
Mar			26,685	27,161		
Total (YTD)		107,352	102,171	103,542	3,810	3.7%

July 2026

26/27	26,884
Plan (B)	27,284
Plan (T)	27,665
Var	(781)
Var %	(2.8%)

Daycase

	Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr		2,386	2,140	2,409	(23)	(1.0%)
May		2,204	2,115	2,384	(180)	(7.6%)
Jun		2,599	2,356	2,633	(34)	(1.3%)
Jul		2,686	2,409	2,722	(36)	(1.3%)
Aug			2,004	2,317		
Sep			2,356	2,669		
Oct			2,303	2,598		
Nov			2,304	2,599		
Dec			2,140	2,435		
Jan			2,168	2,463		
Feb			2,220	2,515		
Mar			2,356	2,651		
Total (YTD)		9,875	9,020	10,149	(274)	(2.7%)

July 2026

26/27	2,686
Plan (B)	2,409
Plan (T)	2,722
Var	(36)
Var %	(1.3%)

Elective

	Mon	26/27	Plan (B)	Plan (T)	Var	Var %
Apr		183	270	314	(131)	(41.6%)
May		215	268	312	(97)	(31.0%)
Jun		218	299	346	(128)	(36.9%)
Jul		268	306	353	(85)	(24.0%)
Aug			254	301		
Sep			299	346		
Oct			290	337		
Nov			290	337		
Dec			270	317		
Jan			274	321		
Feb			279	326		
Mar			299	346		
Total (YTD)		884	1,143	1,323	(439)	(33.2%)

July 2026

26/27	268
Plan (B)	306
Plan (T)	353
Var	(85)
Var %	(24.0%)

Quality and Patient Safety committee metrics

Compassionate care,
healthier communities

Community nursing: deferred care

What?

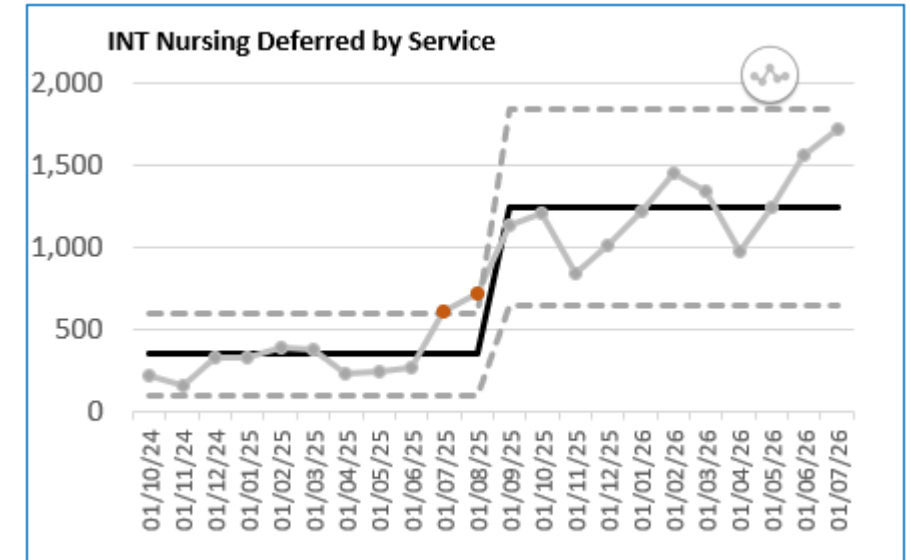
- From September 2025 there is evidence of a sustained shift in the process, as referrals increased, with deferred patients increasing substantially above the previous mean. A new centre line was calculated in accordance with SPC rules, as nurses were encouraged to defer, when no alternative.
- July shows over 10% of all nursing visits were deferred or cancelled. This is cause of concern as a risk to patient safety., identified as a red flag by QNI 2022.
- See risk register RSK 206.

So what?

- The impact of deferred care demonstrates a system under sustained pressure. The high level of deferrals has created need for additional controls to monitor patient safety.

What next?

- The nursing escalation policy is followed to mitigate risk , moving staff to areas of greatest need.
- A successful business case has been recruited to, this will create 10.5 WTE additional capacity in nursing.
- The monthly deferred care audit shows number of harm and level of harm is low, eg delayed wound healing.
- Nurses use a decision support tool , alongside the Red, Amber , Green rating of care plans.
- Continuous QI projects continue to support capacity , such as improving bank capacity, reducing sickness and improving efficiencies in documentation.



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
INT Nursing Deferred by Service	Jul 26	1725				1248	649	1847

Quality and patient safety: post-partum haemorrhage

What?

Post-partum haemorrhage (PPH) is a common obstetric emergency requiring prompt recognition, effective clinical decision-making, and strong multidisciplinary communication. Severe PPH remains the leading cause of maternal mortality globally and is therefore a critical quality and safety priority for maternity services. In **July 2026, thirteen cases of PPH with blood loss >1500ml were reported:**

- **Eleven cases followed caesarean birth**
- **Two cases followed vaginal birth**

These cases have been reviewed in line with the maternity service's established incident review and governance processes. Themes identified continue to focus on timely recognition, appropriate escalation and adherence to the Massive Haemorrhage Protocol where indicated.

So what?

July demonstrates a divergence between caesarean birth and vaginal birth PPH outcomes. Vaginal birth PPH remains low, with **two cases reported (2.0%)**, remaining below the historical mean and continuing the sustained improvement observed over recent months.

Conversely, **LSCS PPH increased to 13.9% (11 cases)** in July, representing the highest monthly rate recorded within the reporting period and exceeding the historical mean.

Initial case reviews have not identified a single common cause. Ongoing multidisciplinary review will focus on maternal risk factors, operative complexity, blood loss estimation, and adherence to escalation processes. The continued low vaginal birth PPH rate provides assurance that improvements in recognition, escalation and management are being sustained across wider maternity pathways

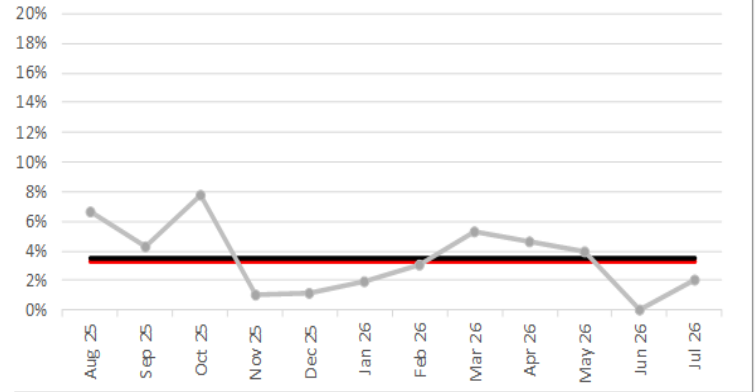
What next?

The maternity service will continue monthly monitoring of PPH rates, with board-level visibility of any upward trends or emerging risks. Focus will be given to detailed review of the July LSCS cases to identify any common contributory factors and determine whether additional improvement actions are required.

Key next steps include:

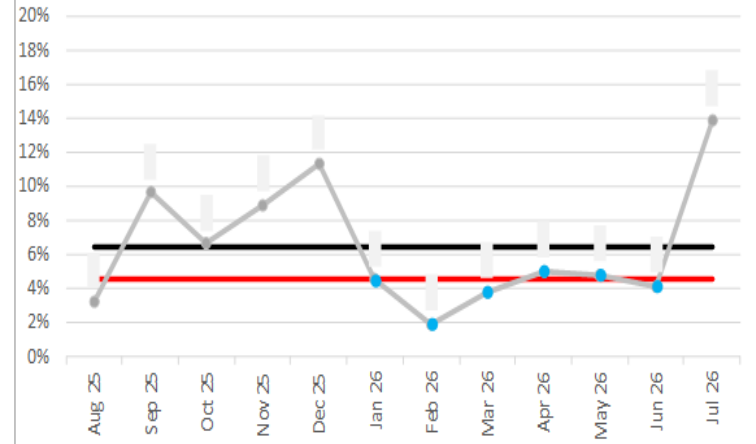
- Trust Quality Improvement Team to support CQI
- Completion of a thematic review of July's LSCS PPH cases by Consultant Obstetrician, including review of risk factors, operative complexity and compliance with local management guidance.- Due 31/10/2026
- Continued promotion and audit of adherence to the Massive Haemorrhage Protocol at 1500ml blood loss.
- Continued multidisciplinary learning through governance, simulation and clinical education forums.

Vaginal births PPH



2 (Jul-Sept 2025)	331	14	4.2%
3 (Oct-Dec 2025)	294	7	2.4%
4 (Jan-Mar 2026)	307	10	3.3%
1 (Apr-Jun 2026)	307	8	2.6%

LSCS PPH



2 (Jul-Sept 2025)	198	10	5.1%
3 (Oct-Dec 2025)	225	19	8.4%
4 (Jan-Mar 2026)	184	6	3.3%
1 (Apr-Jun 2026)	214	9	4.2%

Quality and patient safety: patient safety reports

What?

In July, the total number of reported events increased by 38 compared with the previous month, demonstrating continued staff engagement with incident reporting. The patient safety team continues to compare the monthly proportion of reported harm with national figures from the Learning from Patient Safety Events (LFPSE) data set. WSFT's reported harm rate remained unchanged at 34% in July, continuing to sit below the current national average of 36.01%. Reports of incidents resulting in physical harm were broadly consistent with the previous month, rising slightly from 196 in June to 208 in July.

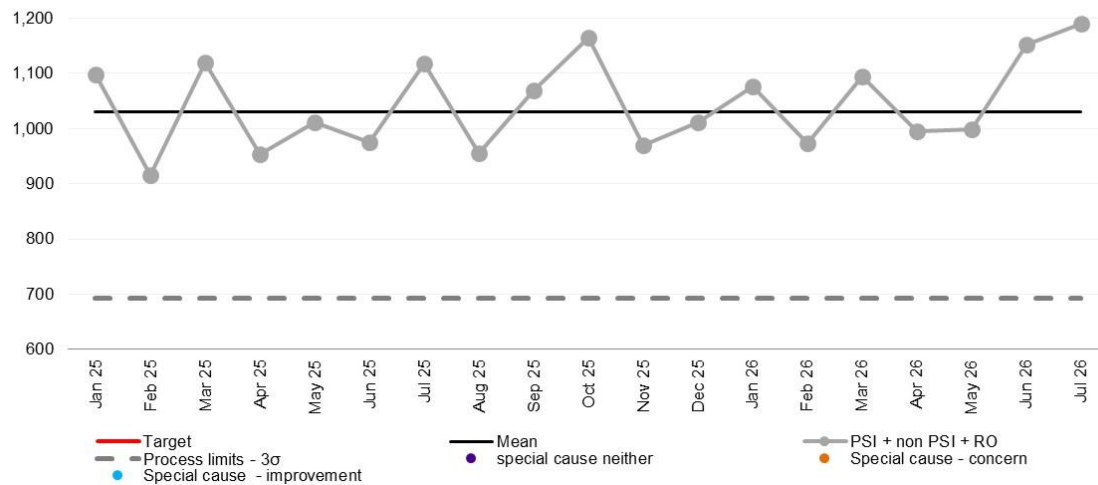
So what?

We continue to promote the reporting of all incidents, recognising that effective reporting supports organisational learning and drives improvement. Reporting activity provides an important measure of our safety culture, while harm data helps us assess the safety of our services. Patient safety incidents and reportable occurrence events are reviewed quarterly and reported to the Quality and Patient Safety Committee. Incidents resulting in moderate harm are managed within divisions, while those involving potential serious or fatal harm are escalated to the Emerging Incident Review (EIR). Through EIR, the most appropriate learning response is agreed in line with the Patient Safety Incident Response Plan (PSIRP), ensuring learning is identified, shared and translated into meaningful safety improvements across the organisation.

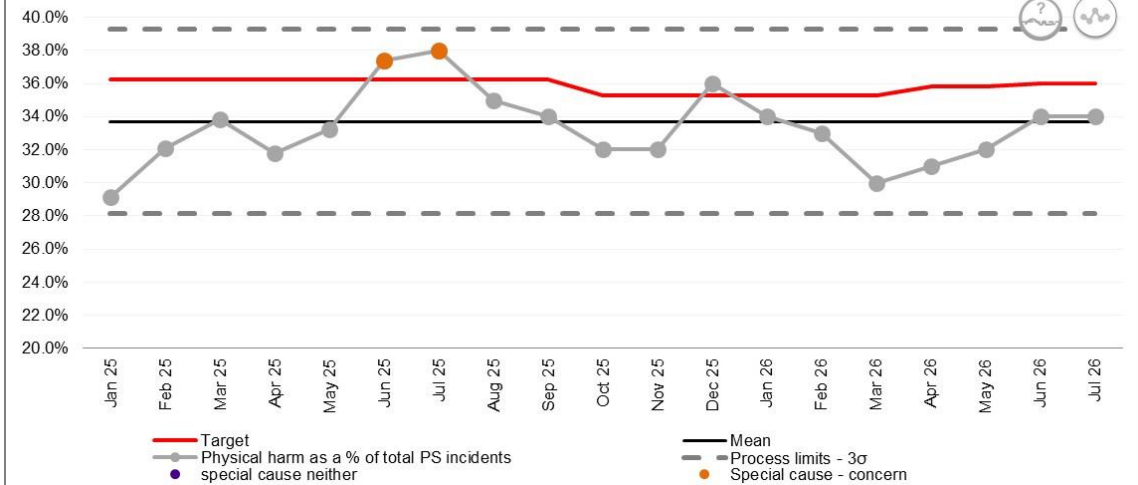
What next?

The insights gained from this analysis, together with the outcomes of the quarterly patient safety report, will continue to be shared with divisional governance teams and speciality leads to inform focused improvement initiatives. These insights also contribute to trust-wide safety discussions, supporting timely escalation and action whenever harm levels or incident trends indicate the need for further scrutiny.

Measuring reporting rates as a safety culture indicator-Number of incidents and ROs reported starting 01/01/25



Measuring harm as a safety indicator-Number of patient safety incidents (PSIs) with harm as a % of total PSIs starting 01/01/25



Quality and patient safety: Summary Hospital-level Mortality Indicator (SHMI)

What?

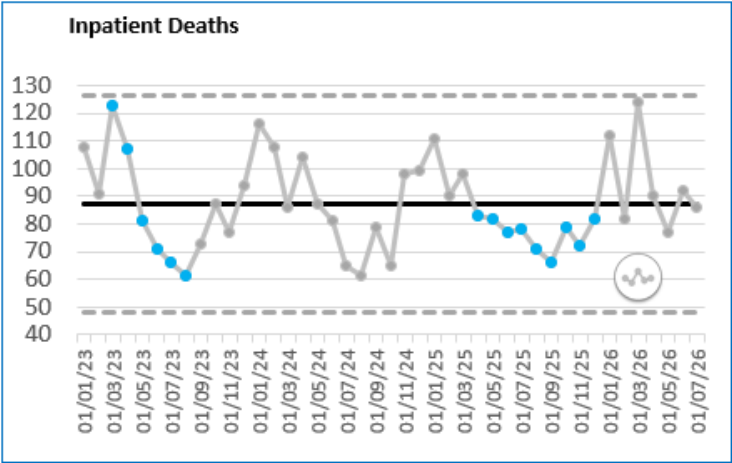
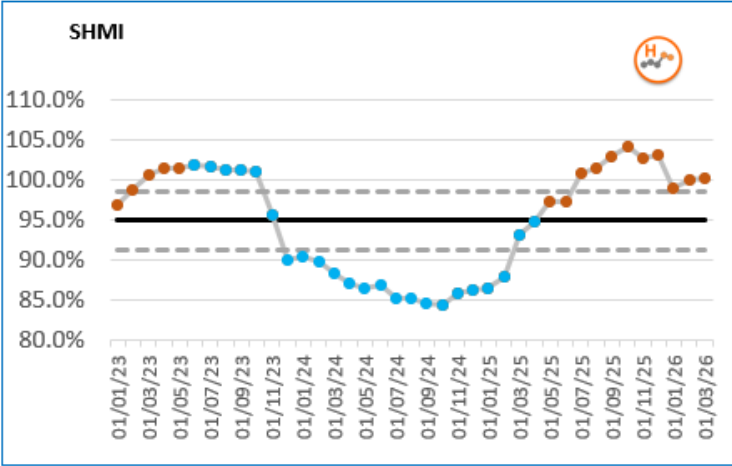
- In July 2026, there were 87 adult inpatient deaths at WSFT.
- The Trust's SHMI data is currently showing an elevated trend due to a coding anomaly relating to the March 2025 reporting period, which became apparent in September 2025. During this period, uncoded patient episodes were placed in the "invalid primary diagnosis" category.
- As a result, the number of deaths recorded within the "invalid primary diagnosis" category was significantly higher than expected, creating an artificial spike in the Trust's SHMI data.

So what?

- The increase in the Trust's SHMI is not indicative of a deterioration in the quality of care. Rather, it reflects a coding backlog that occurred when clinical coders were unable to meet national submission deadlines.
- Since April 2026, all current episodes have been coded within required timescales and live coding activity remains up to date.
- However, a number of deaths from February and March 2026 still require final coding. These cases currently remain within the "invalid primary diagnosis" category, which continues to contribute to higher-than-expected mortality figures within that specific classification.
- All outstanding deaths from February and March 2026 are scheduled to be coded by 1 September 2026. As SHMI is reported with a six-month time lag, the Trust's SHMI data is expected to remain unstable for up to six months following completion of the retrospective coding exercise.

What next?

- The Trust will continue to monitor and analyse mortality data through the Mortality Oversight Group and the independent Medical Examiner Service.
- Assurance is provided through monthly mortality reporting within the Learning from Deaths programme and through ongoing review of National Cardiac Arrest Audit data. These sources currently indicate that the Trust is performing as expected, with no unusual trends, concerns, or areas of increased mortality identified.



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Mar 26	100.3%				95.0%	91.4%	98.6%
Inpatient Deaths	Jul 26	86				87	48	126

Quality and patient safety: complaints

- Volume of complaints resolved late have increased from 4 in June to 7 in July.
- During this reporting period, 26 complaints were received which is a 63% increase from June. The largest proportion related to patient care concerns (26%), with a subcategory of 'care needs not adequately met'. The Medicine division accounted for 61% of complaints with the emergency department accounting for 7 of these complaints. Recurring themes include Care needs not adequately met and Delay or failure in acting on reports

So what?

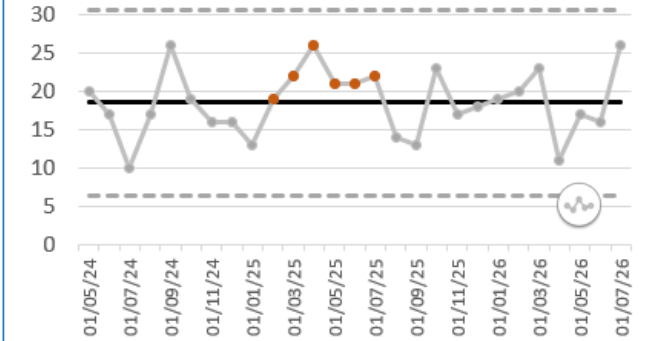
- Complaints resolved late have increased to 7, predominantly due to delayed staff responses.
- PALS are logging all concerns following from a refresher session with the team and amendments made with RADAR to ensure compliance.

What next?

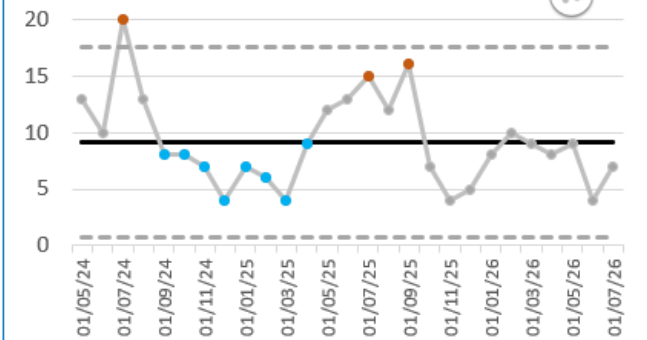
- Patient experience team are attending regular tri meetings to discuss upcoming and overdue complaints for more divisional accountability.
- New governance feedback loop process put in place with divisions to analyse themes and report back through the experience of care and engagement committee focussing on outcomes and learning.
- Complaint timeframes are in the process of being reviewed and adjusted, in line with a severity and complexity matrix.
- Initially 2 PALS officers started in August however 1 resigned. New advert out with immediate effect.

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Formal Complaints Received	Jul 26	26		📈		19	7	31
Formal complaints resolved late (>25 wd)	Jul 26	7		📈		9	1	18
PALS Received	Jul 26	187		📈		211	98	323

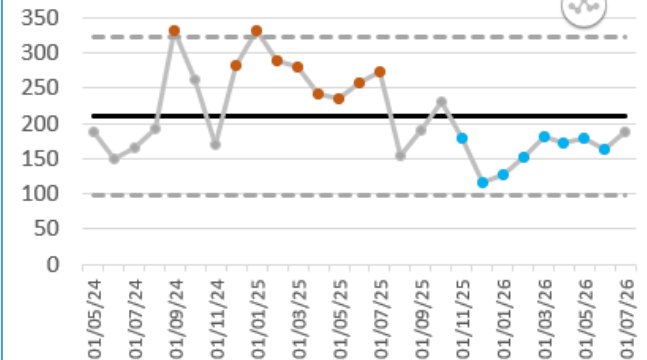
Formal Complaints Received



Formal complaints resolved late (>25 wd)



PALS Received



People and Organisational Development committee metrics

Compassionate care,
healthier communities

Workforce & organisational development metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jul 26	4.9%	5.0%			4.8%	4.7%	4.9%
Staff Sickness - monthly	Jul 26	4.9%	5.0%			4.8%	4.7%	4.9%
Mandatory Training monthly	Jul 26	90.4%	90.0%			89.7%	88.1%	91.2%
Appraisal Rate monthly	Jul 26	80.3%	90.0%			85.4%	83.0%	87.7%
Turnover rate monthly	Jul 26	8.8%	10.0%			9.3%	8.5%	10.1%

What?

- Sickness – 4.9% 12-month rolling performance versus 5% target.
- Mandatory Training – marginally achieving target this month at 90.4% versus 90% target.
- Appraisal – consistently failing target, 80.3% versus 90% target.
- Turnover – achieving target, 8.8% versus 10% target.

So what?

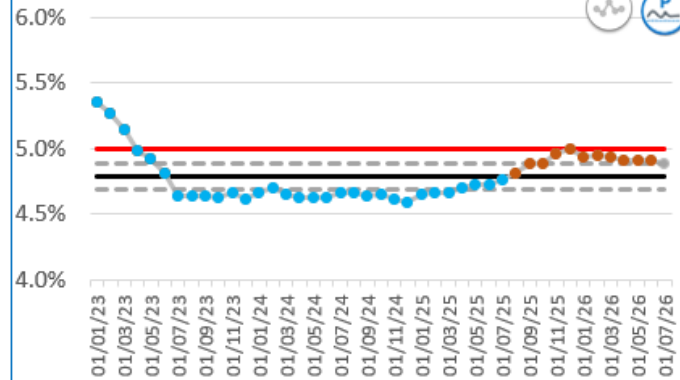
- These workforce key performance indicators directly impact on staff morale and engagement, staff retention, and therefore, patient care and safety.
- Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.

What next?

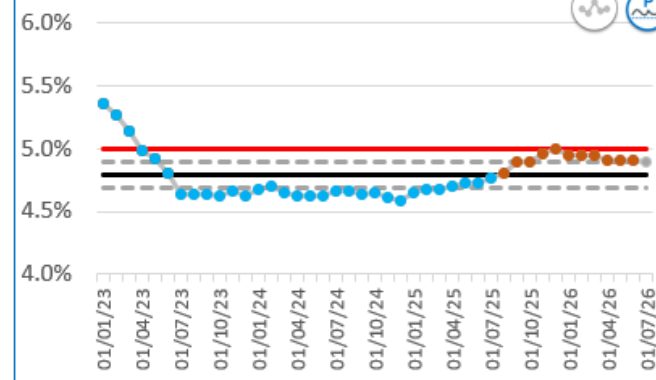
- Monitor staff attendance at department level with focus where improvement is required.
- Review compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required.
- Continued analysis of appraisal data to support and challenge areas in need of action and improvement.
- Maintain focus on the delivery of our people and culture plan and priorities.

Workforce & organisational development metrics

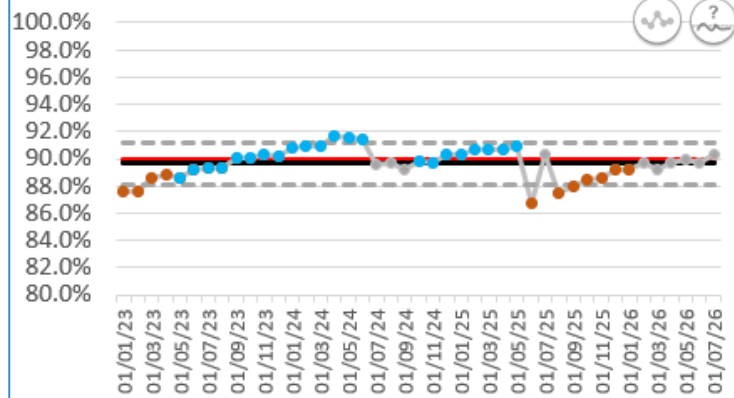
Staff Sickness - rolling 12month



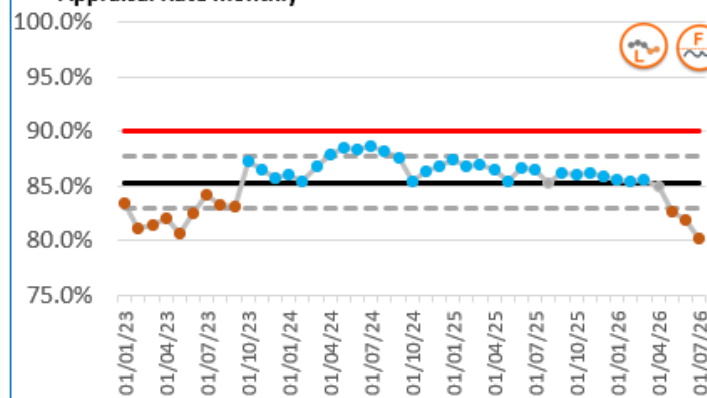
Staff Sickness - monthly



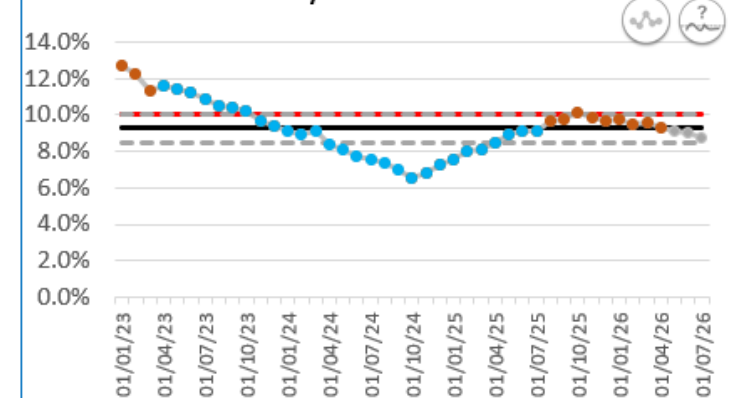
Mandatory Training monthly



Appraisal Rate monthly



Turnover rate monthly



Appendices: understanding MDC

Compassionate care,
healthier communities

Making Data Count (MDC): understanding the charts

NHS England's 'Making Data Count' programme uses statistical process control charts to provide an 'at a glance' method of understanding performance.

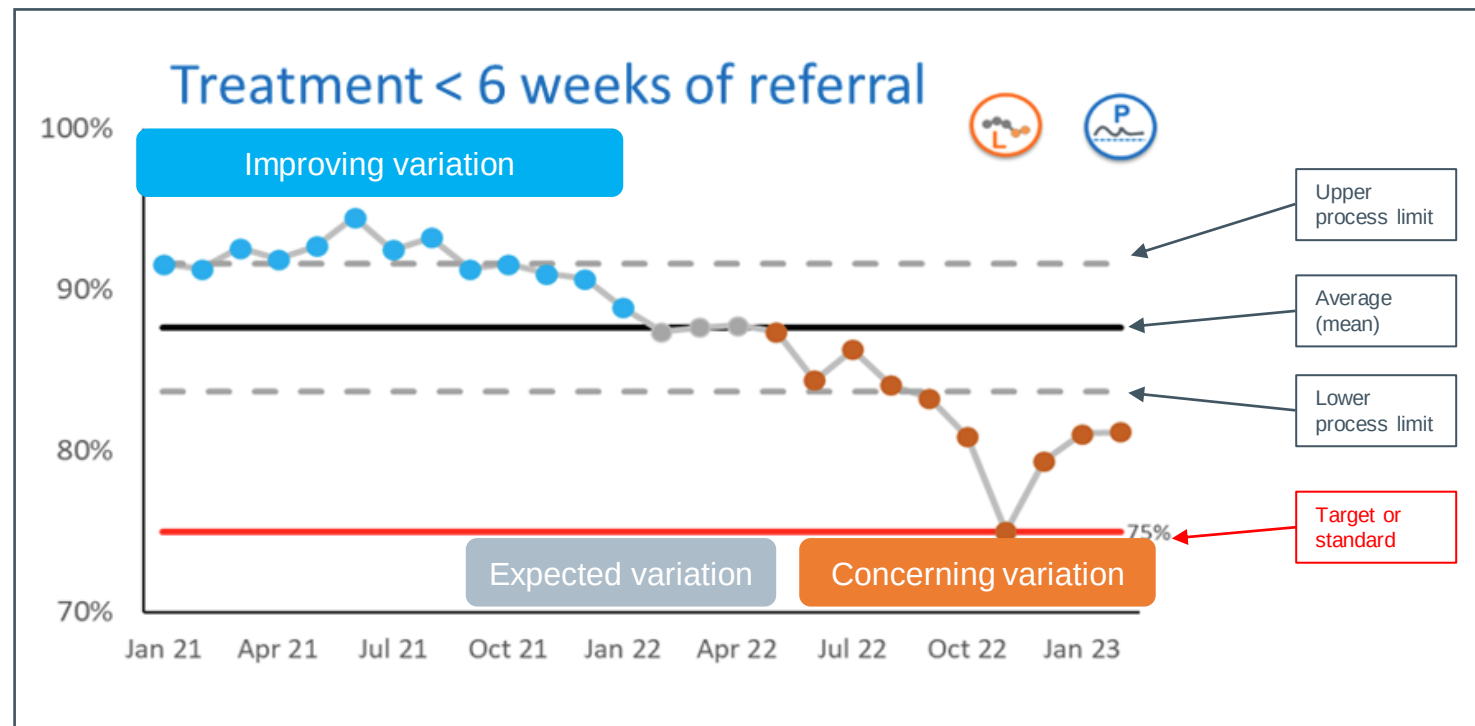
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented.

Blue – there is a pattern of improvement which should be learnt from.

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the red line) can be achieved always, never (as in this example) or sometimes. SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a glance view. These are described on the following page.

Concerning and improving variation are statistically significant patterns in data which may require investigation, including:

- Trend: 6 or more consecutive points trending upwards or downwards
- Shift: 7 or more consecutive points above or below the mean
- Outside control limits: One or more data points are beyond the upper or lower control limits

Making Data Count (MDC): interpreting SPC icons

Icons for variation and performance

Icon	Description	What does this mean?	What do we do next?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction.	Investigate to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction.	Find out what is happening / has happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
	Special cause variation where neither high nor low is good.	Something's going on!	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something

Icons for assurance

Icon	Description	What does this mean?	What do we do next?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Making Data Count (MDC): reading the assurance grid

The assurance grid provides an overview of performance, summarising where our metrics are landing and what action is suggested.

Variance – are the measures being met?

Assurance – can the target be consistently achieved?				
	Consistently hitting target 	Target not consistently achieved or failed 	Consistently fail target 	No target set
Special cause improvement 	Excellent Consistently achieving the target and metric is improving Celebrate and learn	Good Target will not be consistently achieved but metric is improving Celebrate and understand	Concerning Metric is improving but target is consistently failing and won't be achieved without change Celebrate but take action	Excellent Metric is improving, no target has been set Celebrate
Common cause 	Good Consistently achieving the target and metric is not changing significantly Celebrate and understand	Average Target will not be consistently achieved, and metric is not changing significantly Investigate and understand	Concerning Metric not changing significantly, but target is consistently failing and won't be achieved without change Investigate and take action	Average Metric is not changing significantly and shows levels of natural variation that is expected, no target has been set Understand
Special cause concerns 	Concerning Target is being achieved but metric is deteriorating Investigate and understand	Concerning Metric not consistently achieved and metric is deteriorating Investigate and take action	Very concerning Metric is deteriorating and target won't be achieved without change of process Investigate and take action	Concerning Metric is deteriorating, no target set Investigate

COMFORT BREAK (10 mins)

3.2. Quality & Patient Safety Committee - Committee's Key Issues (ATTACHED)

To Assure

Presented by Paul Zollinger-Read

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee Quality & Patient Safety Committee			Date of meeting: 19 August 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
6.1	Mortality oversight group report - Increase in Prevention of future death (PFDs) reports being issued by coroner - Need to improve completion of ReSPECT forms. 44% completion on audit - SHIMI coding data backlog.	2	PFD: WSH experiencing significant challenges from some coroners which is leading some clinicians anxiety in attending ReSPECT: As a recognised document used across acute, community and primary care settings, ReSPECT helps ensure that patient preferences are communicated, understood and respected throughout their healthcare journey, particularly if they are unable to express their wishes in the future. SHIMI: Review of all deaths accruing in care supports assurance around expected levels	ReSPECT Improvement Programme: Policy update: The timeframe for completing a ReSPECT extended from 72 hours to one week to support more meaningful patient and family engagement. eCare enhancement: Automated reminders have been introduced to prompt completion of a ReSPECT discussion and plan 7 days after a DNACPR decision. SHIMI: Not expected to see SHIMI reflect accurate coding until Dec 2026	Assure	1. No escalation

Originating Committee Quality & Patient Safety Committee			Date of meeting: 19 August 2026			
Chaired by: Dr Paul Zollinger-Read			Lead Executive Director: Dan Spooner – Executive Chief Nurse / Dr Richard Goodwin – Executive Medical Director			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
6.2	Mental health learning from recent incidents suggests delays in in seeking urgent Mental health inpatient advice; this has been in children's services and maternity. No harm but learning	2.	Timely access to mental health service for inpatient ensures patients have the right intervention at the tight time. Increasing frequency and delays in CYP inpatient stay for CYP to access onward care and discharge	A series of Trust-to-Trust meeting has occurred to determine how our existing SLAs can be fully utilised. Mental health lead attends all system MH capacity meetings to ensure WSFT challenge is escalated Exec to exec discussion with NSFT to remove pathway barriers have been effective	Alert	1. No escalation
7.1	QDG BLs rates remain around 80% for trust compliance	3.	BLS is part of mandatory training suit to provide assurance around safe and effective services. While compliance remains below 90%. National cardiac arrest audit is favourable	Trainer vacancy now filled should improve training access and increase adhoc sessions for medical team (lowest compliance group)	Assure	2.

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence...	Further consideration...
 What? Deepening understanding of the evidence and ensuring its validity	Validity – the degree to which the evidence... • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
 So what? Increasing appreciation of the value (importance and impact) – what this means for us	Value – the degree to which the evidence... • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
 What next? Exploring what should be done next (or not), informing future tactic / strategy, agreeing follow-up and future evidence of impact		• Recommendations for action • What impact are we intending to have, by when and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

Definitions

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	Inform	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	Assure	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A formal decision-making step by the reporting committee that something meets required standards and can proceed or be implemented.		

3.3. Nursing staffing report - including strategy (ATTACHED)

To Assure

Presented by Daniel Spooner and Sarah Ward

Public Board

Report information

Report title: Nursing and Midwifery safe staffing report: July and August 2026 review

Agenda item:

Sponsor/Executive lead: Daniel Spooner: Executive Chief Nurse

Report prepared by: Sarah Ward : Deputy Chief Nurse and Julie Wiggin: PA to DCN

Previously considered by:

This report is for: ☐ Approval ☒ Assurance ☐ Discussion ☒ Information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What?

The report provides a retrospective overview of safe staffing levels, fill rates and key quality indicators across inpatient areas for July and August 2026.

It complies with National Quality Board (NQB) recommendations by demonstrating effective deployment and utilisation of nursing and midwifery staff. It outlines planned versus actual staffing, highlights areas where staffing shortfalls occurred, and describes actions taken to mitigate them where possible. The report also reviews vacancy levels, nurse-sensitive quality indicators and recruitment activity. It describes how nursing and midwifery workforce deployment is supporting the Trust's wider financial sustainability ambitions while maintaining a focus on patient safety and care quality.

So what?

- Care Hours Per Patient Day (CHPPD) remains in the lower national quartile (Model Hospital data June 2026), indicating need for continued triangulation with quality, acuity and professional judgement.
- Sickness absence levels remain stable, although unregistered workforce resilience remains a risk.
- Robust oversight of temporary nursing spend continues through the Nursing and Midwifery Deployment Group.
- Overall fill rates at 90.25% and 90.25% in July and August respectively.

What next?

- Continued oversight of temporary staffing spend controls with monitoring of any associated safety risks.
- Sustained focus on recruiting and retaining nursing assistants to strengthen the unregistered workforce.
- Continue recruitment linked to the approved community nursing investment business case, with progress monitored through divisional and nursing governance routes.
- Complete analysis of acuity and dependency census data (SNCT, CNSST II and Birthrate Plus) to inform annual establishment reviews.

Action required by the board:

The Board is asked to receive assurance that nursing and midwifery staffing is actively monitored and mitigated through daily operational oversight, establishment review and governance routes, while noting the residual risks relating to community capacity, nursing assistant workforce resilience and lower CHPPD benchmarking.

Governance and compliance

Risk and assurance:

Robust systems are in place to assure safe nurse / midwifery staffing, including daily escalation, data triangulation and oversight through established governance forums.

Mitigations are in place and actively monitored. Overall, risk remains controlled but requires continued oversight.

Equality, diversity and inclusion:

Enabling a diverse and engaged workforce improves patient outcomes. Safe staffing levels positively impact staff engagement, retention and the delivery of safe care.

Sustainability:

The Trust continues to balance safe staffing with financial sustainability through:

- Reduction in temporary staffing spend
- Improved rostering and deployment efficiency
- Ongoing review of workforce establishments (SNCT, CNSST)
- Workforce investment, particularly in community services, supports long-term service sustainability and aligns with system priorities to shift care closer to home.

Legal and regulatory context:

This report supports compliance with:

- CQC Fundamental Standards, particularly Regulation 12 (Safe care and treatment) and Regulation 18 (Staffing)
- National Quality Board (NQB) safe staffing guidance
- CNST maternity safety requirements
- The Trust continues to demonstrate compliance with expectations for the provision of safe, effective, and well-governed care, supported by regular review of staffing, quality indicators, and escalation processes.

Nursing and Midwifery safe staffing report : July and August 2026

1. Introduction

The paper provides the Board with a retrospective assessment of nurse and midwifery staffing levels, fill rates and key quality indicators across inpatient areas for July and August 2026. The Trust continues to maintain safe nursing and midwifery staffing overall, with stable quality indicators and full compliance with maternity safety standards.

There are no immediate patient safety concerns directly attributable to staffing levels. However, there are emerging and ongoing risks relating to:

- Community service capacity and care deferrals
- Lower care hours per patient day (CHPPD) compared to peers
- Sustained workforce gaps in nursing assistants (NAs)

Robust systems for daily staffing oversight, escalation, and mitigation remain effective, and targeted actions are in place to address these risks.

2. Background

The National Quality Board (2016) identifies three expectations (Table 1.) that form a triangulated approach to staffing decisions. This approach supports staffing decisions based on patients' needs, acuity and risk, monitored from "ward to board".

NHS provider Boards are required to ensure proactive, robust and consistent approaches to safe staffing.

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	Right Skills 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	Right Place and Time 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1. NQB safe, sustainable and productive staffing

3. Right staff, right skills, right place and time

The Trust conducts comprehensive nurse establishment reviews twice per year across acute settings using the full suite of licensed Safer Nursing Care Tools (SNCT), the Community Nursing Safer Staffing Tool (CNSST II) across community settings and Birthrate Plus for maternity services.

The Nursing and Midwifery Deployment Group (NMDG) provides monthly oversight of nursing and midwifery workforce deployment, reviewing staffing levels, acuity, fill rates, workforce risks and temporary staffing controls. The group enables assurance that staffing decisions are clinically led, data-informed and aligned to safe, effective care, while also contributing to financial sustainability through oversight of temporary staffing use.

On a daily basis, acuity and dependency are formally reviewed three times per day during staffing meetings, with a RAG-rated score included in the Trust-wide capacity report.

3.1 Nursing Fill Rates

The Trust's safer staffing data has been submitted to NHS Digital for July and August 2026. This is monitored at ward level (Appendices 1a and 1b). Overall fill rates remain stable (Table 2 and Chart 1), with no deterioration in harm indicators.

Average fill rate (planned vs actual)	Day		Night	
	Registered	Care Staff	Registered	Care staff
April 2026	87%	80%	92%	92%
May 2026	90%	85%	96%	97%
June 2026	87%	84%	94%	100%
July 2026	86%	84%	93%	98%
August 2026	87%	85%	93%	96%

Table 2. Summary of overall trust fill rate percentages for M4 and M5 (previous three months for comparison).

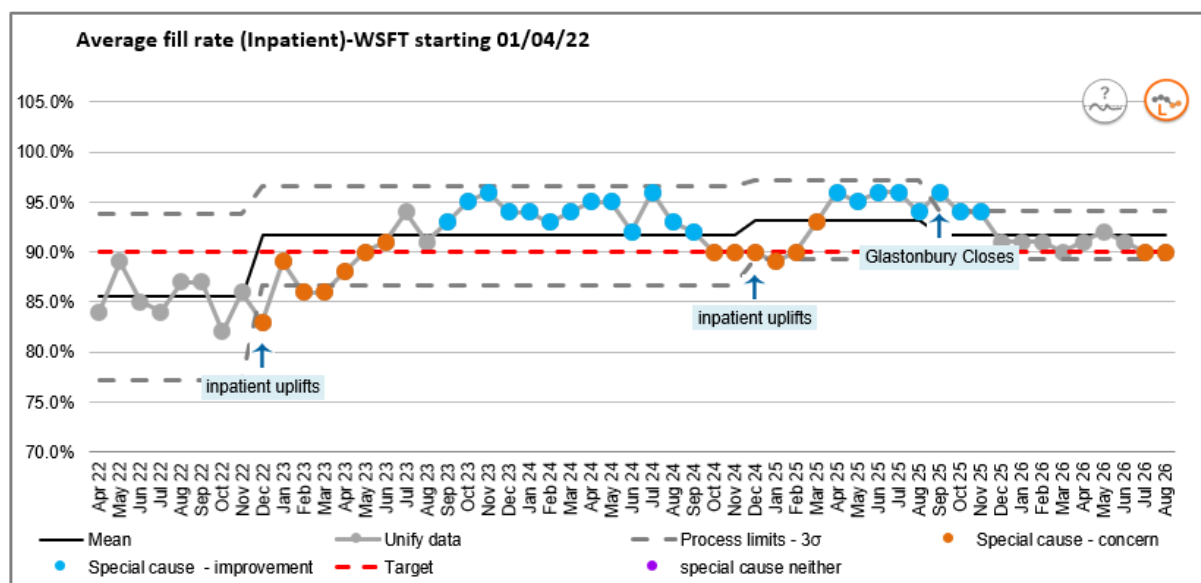


Chart 1. Overall nursing fill rates registered / non registered combined day/ night shifts

3.2 Care hours per patient day (CHPPD)

Model Hospital data (Appendix 2) demonstrates that WSFT remains in the lower national quartile for CHPPD, recorded at 7.1 in July and 7.3 in August 2026. Although there is a small improvement between months, the benchmarked position indicates ongoing workforce pressure and continues to be triangulated with fill rates, acuity and dependency, quality indicators and professional judgement to support safe staffing assurance.

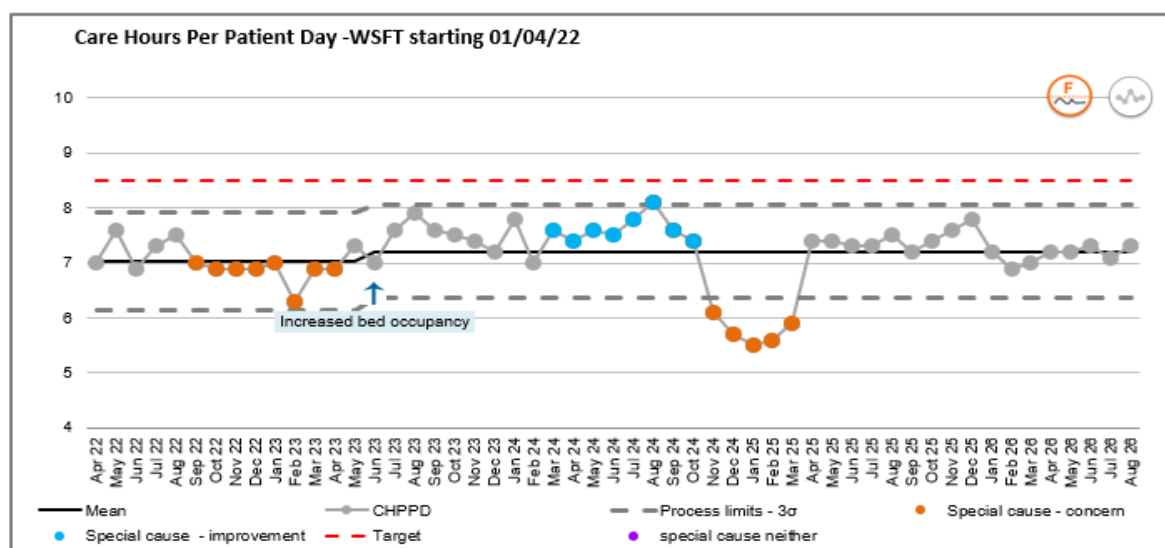


Chart 2. Care Hours Per Patient Day

3.3 Mandatory training

Mandatory training compliance for registered nurses, midwives and nursing assistants remains above the Trust target of 90%, providing assurance that staff have the core skills required to support safe care. While some training is postponed in times of operational demand, this is considered in context during daily staffing meetings.

Staff group	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Additional Clinical Services	92%	93%	93%	93%	93%	93%
Nursing and Midwifery Registered	91%	91%	91%	91%	91%	92%

Table 3. Mandatory training for last 6 months, registered and unregistered care staff

3.4 Recruitment and retention

Vacancies: The registered nursing and midwifery workforce remains broadly stable, with an overall RN/RM vacancy rate of **8.8%** in July and **7.3%** in August. The principal workforce risk remains within the unregistered workforce, where the NA vacancy rate was **11.5%** in July and **10.7%** in August. Inpatient substantive WTE data shows a month 5 vacancy position of **58.6** WTE for registered nurses and **43.3** WTE for nursing assistants. Although NA substantive staffing levels have remained relatively stable over the reporting period, the higher vacancy rate and continued turnover indicate an ongoing risk to workforce resilience.

Table 4. demonstrates the total RN/RM establishment for the inpatient areas in whole time equivalents (WTE). Full suite of SPC charts related to vacancies and WTE can be found in Appendix 3.

	Sum of Month 12	Sum of Month 1	Sum of Month 2	Sum of Month 3	Sum of Month 4	Sum of Month 5	WTE vacancy at M5
RN	703.3	685.4	681.9	681.3	683.2	695.1	58.6
NA	368.6	363.6	362.7	365.7	362.9	365.7	43.3

Table 4. Inpatient actual substantive staff and vacancies at month 5 in WTE

New starters: Recruitment and retention actions remain focused on strengthening the unregistered workforce, while maintaining oversight of RN/RM vacancy trends through the Nursing and Midwifery Deployment Group and associated workforce governance routes.

Table 5. demonstrates registered and non-registered staff commencing induction at WSFT. Induction attendance for registered nurses has increased in the last 2 months in line with newly qualified cohorts.

	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26	July 26	August 26
RN/RM	10	6	24	-	11	5	13	12
NA	24	14	14	13	6	11	11	16

Table 5: Data from HR for attendance at WSFT induction program.

During July

- 13 registrants attended induction (10 RNs acute, 2 RN bank staff, 1 Midwifery).
- 11 NAs attended induction (11 NAs acute)

During August

- 12 registrants attended induction (10 RNs acute, 2 RNs Community)
 - 16 NAs attended induction (14 NAs acute, 1 NA bank staff and 1 NA community).

Turnover: On retrospective review of the rolling twelve-month position, registered nurse and midwife turnover has remained stable and below the Trust ambition of 10%, reducing to **7.5%**. This provides assurance regarding registered workforce stability.

Turnover within the unregistered workforce has reduced but remains above **10%** and continues to represent a workforce resilience risk. Although nursing assistant recruitment has been positive during the last quarter, this has not yet been sufficient to fully offset turnover. Individual-level analysis is informing targeted retention actions to reduce the gap and strengthen the unregistered workforce.

3.5 Sickness

Table 6. demonstrates an overall improvement in nursing and midwifery sickness absence since the winter peak, with combined registered and unregistered absence reducing from **6.60%** in December 2025 to **5.34%** in August 2026.

Unregistered staff continue to have the highest absence rates at **6.23%**. Registered nurse and midwife sickness remains comparatively lower in August just below **5%**. Focus continues on attendance improvement, particularly within the unregistered workforce to support safe staffing.

	Jan 26	Feb 26	Mar 26	Apr 26	May 26	June 26	July 26	August 26
Unregistered staff (HCSW)	6.74%	7.30%	6.23%	6.94%	6.28%	5.97%	5.73%	6.23%
Registered Nurse/Midwives	5.44%	5.20%	4.23%	4.31%	4.49%	4.99%	5.51%	4.92%
Combined Reg/Unregistered	5.85%	5.87%	4.86%	5.14%	5.06%	5.30%	5.58%	5.34%

Table 6. sickness absence as a % across registered and unregistered nursing/ midwifery staff

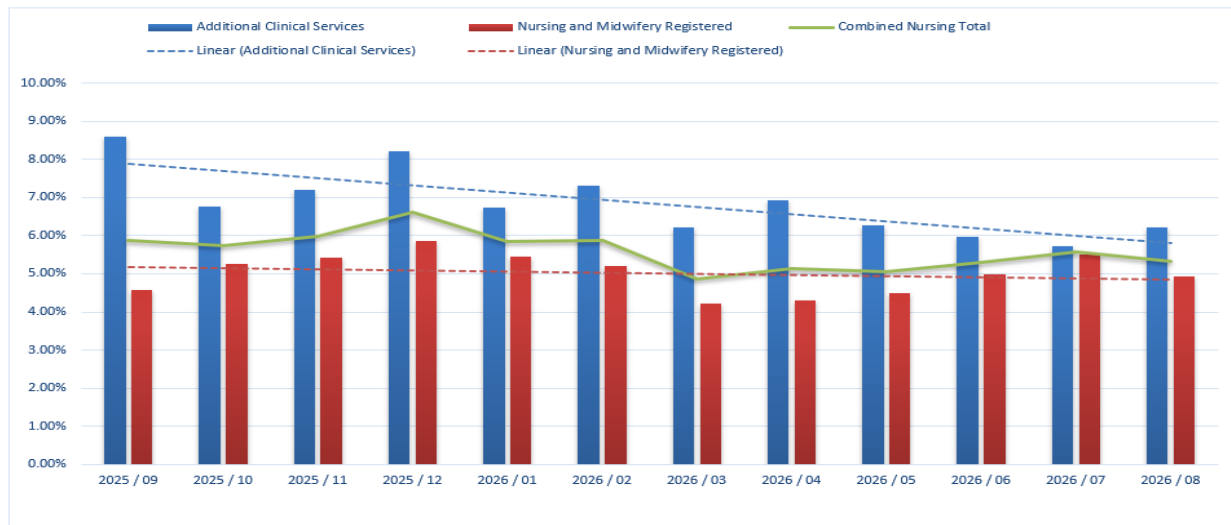


Chart 3. Nursing and midwifery sickness absence by staff group, November 2025 to June 2026.

4. Quality and Safety

4.1 Falls and acquired pressure ulcers

Improvement projects and oversight of these quality indicators are reviewed through the Quality Delivery Governance Group (QDGG). Fall incidents in this period remain in common cause variation as do falls per 1000 bed days.

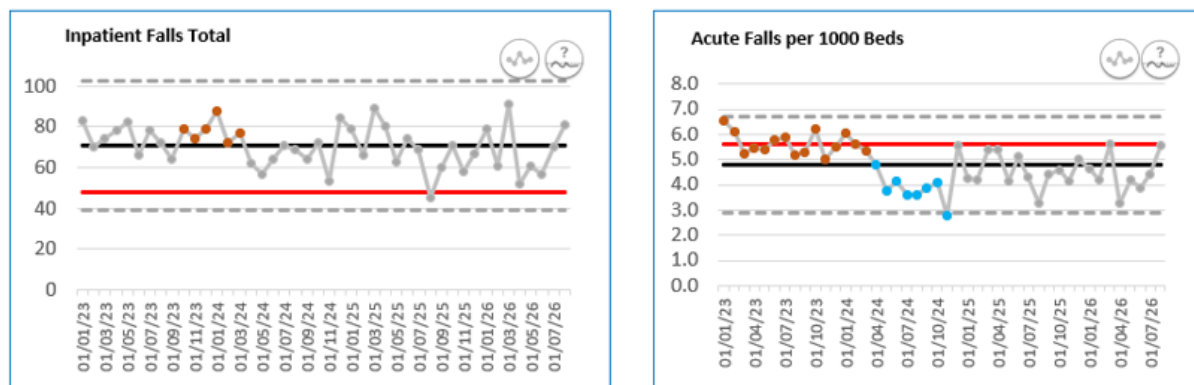


Chart 4. Inpatient falls total and per 1000 bed days

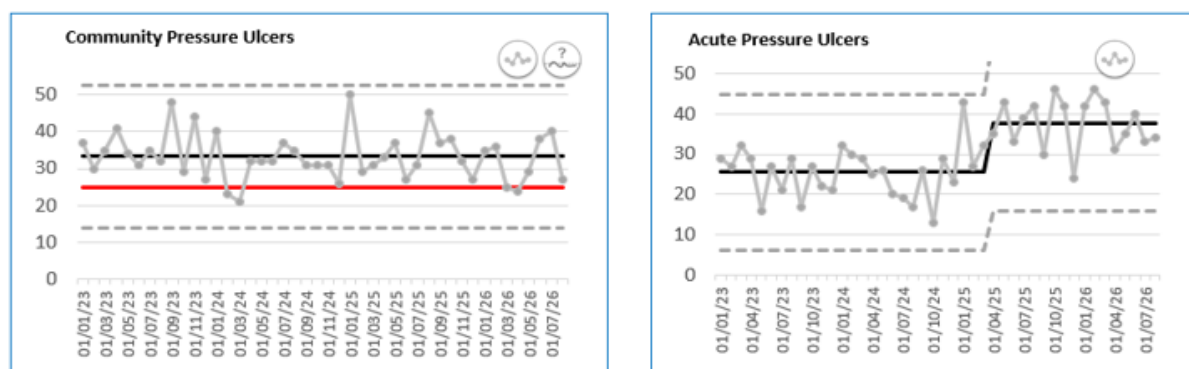


Chart 5. Pressure ulcers acquired in care, community and acute

4.2 Staffing incidents

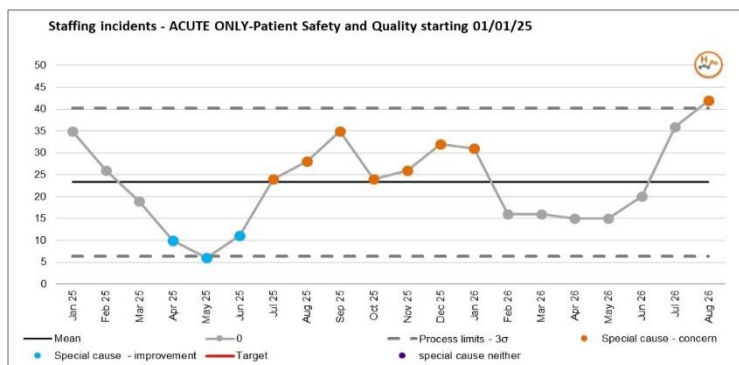


Chart 6. Acute only reported staffing incidents.

Increase in reporting noted. All incidents over the last 12 months have been reviewed, with one incident related to staffing graded as moderate. All other incidents graded as no or low harm.

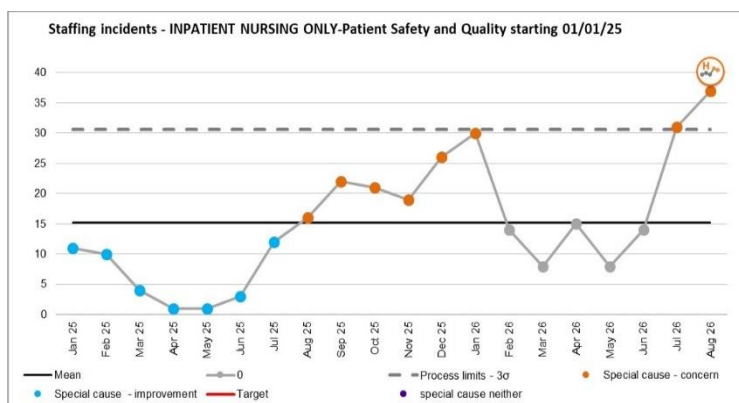


Chart 7. Inpatient only reported staffing incidents.



Chart 8. Community only reported staffing incidents.

Community staffing incidents have remained largely within expected variation, with spike in March 2026 aligned to rising demand and care deferrals.

4.3 Red Flags

Red flags as per NQB guidance (Appendix 4) have been reported via RADAR from M9 24/25 (Chart 9). The most common Red Flag event reported remains inpatient nurse staffing shortfall impacting on care. Red flags are mitigated through the rhythm of staffing meeting throughout the day.

To enhance assurance, a refreshed proposal to report red flags contemporaneously on SafeCare, mitigate against acuity and dependency is being progressed to commence by the end of the calendar year.

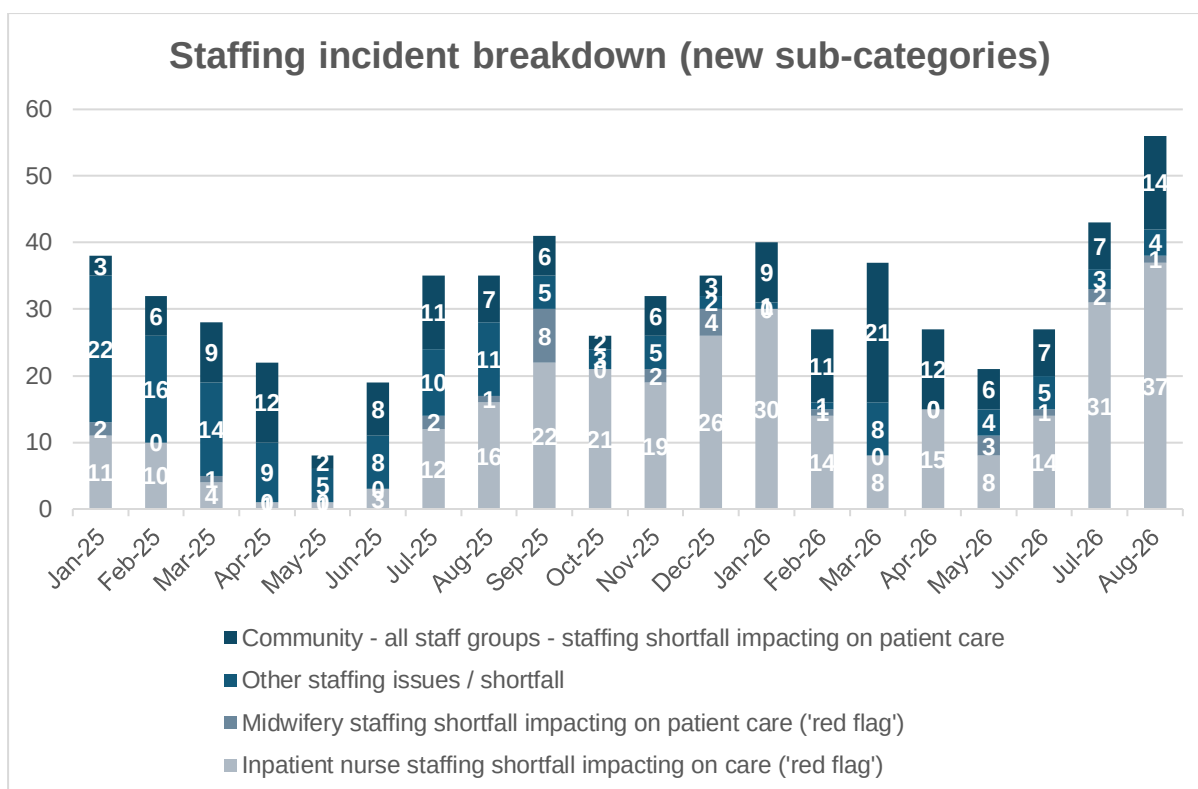


Chart 9.Red flag reported by month and category.

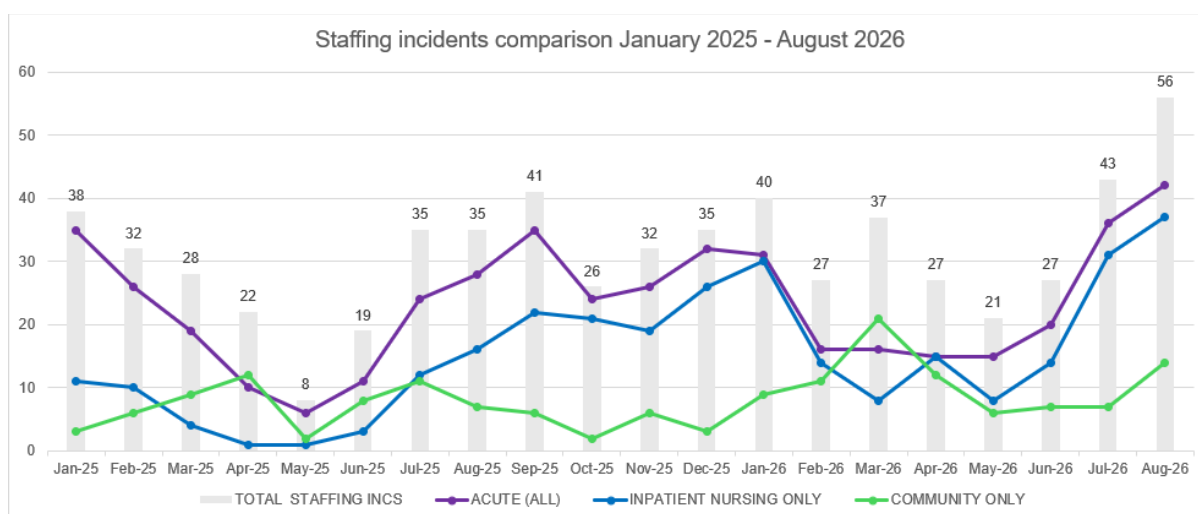


Chart 10. staffing incidents comparison

5. Maternity services

A full maternity staffing report will be included in the maternity paper as per CNST requirements.

5.1. One to one care in labour

The guidance originates from NICE's second guideline regarding safe staffing within the NHS, which outlines recommendations for midwifery staffing levels to support women and their babies in any chosen environment. This guidance is also one of the ten Safety Actions included in the Maternity Incentive Scheme. Maternity services are required to offer women in

established labour dedicated one-to-one support, as childbirth can present significant safety challenges and is crucial for ensuring a secure birthing experience. Plans for escalation have been established to address unforeseen fluctuations in demand.

5.2 Maternity Red Flag events

NICE Safe Midwifery Staffing for Maternity Settings 2015 identifies Red Flag events as immediate indicators that a problem exists, necessitating prompt action to prevent further deterioration. This action involves escalating the issue to the senior midwife/Duty Manager who is maintaining an overview of the service, with a response that may include the allocation of additional staff to the affected ward or unit.

All Red Flag events are recorded in RADAR and addressed during the daily Maternity Safety Huddle, where they are discussed, highlighted, and mitigated as necessary.

There were **2** Red Flag events recorded in this reporting period. This is a reduction since the previous reporting period.

These relate to the delay of women admitted for their labour to be induced (beyond 6 hours) . No patient harm occurred due to these delays. To mitigate risk here are regular oversight huddles to prioritise women who have significant risk factors. Furthermore, patients are given 6 hourly updated by the duty manager following patient experience feedback.

5.3 Midwife to Birth ratio

The midwife-to-birth ratio is no longer considered an accurate standalone measure of safe staffing; all other maternity staffing metrics remain in place.

5.4 Supernumerary status of the labour suite co-ordinator (LSC)

This requirement is part of the Maternity Incentive Scheme Safety Actions (Table 7) and was emphasised as a recommendation in the CQC report from January 2020. The band 7 labour suite coordinator should not be directly responsible for the care of women. This approach allows the coordinator to maintain situational awareness of the unit's activities and is acknowledged as both best and safest practice.

The Labour Suite Coordinator remained supernumerary throughout this reporting period and achieved through the financial year. This is an important safety standard and reflects a well led and responsive service.

	Standard	Jan	Feb	Mar	Apr	May	June	July	Aug
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. Red Flags reported	NA	0	1	0	0	3	1	1	1

Table 7. Maternity Incentive Scheme safety actions key metrics

6. Community and integrated neighbourhood teams (INT)

6.1 Workforce

Sickness Adults: 6.54% a slight rise on previous month. There is significant variation between teams, one INT has **20%** sickness.

Sickness Therapies: 5.75% maintained at previous level. Action plan commenced to improve sickness across the service.

Turnover: rates have reduced since last month and stand at **10.2%**.

Fragility of small services

The recent impact of sickness within the nutritional nursing team has reinforced the fragility of small specialist services. Existing risk assessments have been reviewed, and the learning has highlighted the need to strengthen business continuity arrangements for small specialist teams.

6.2 Demand and capacity

Demand for community nursing services remains sustained and has been on an upward trend throughout 2025 and 2026. Chart 11. demonstrates increase in demand over this period.

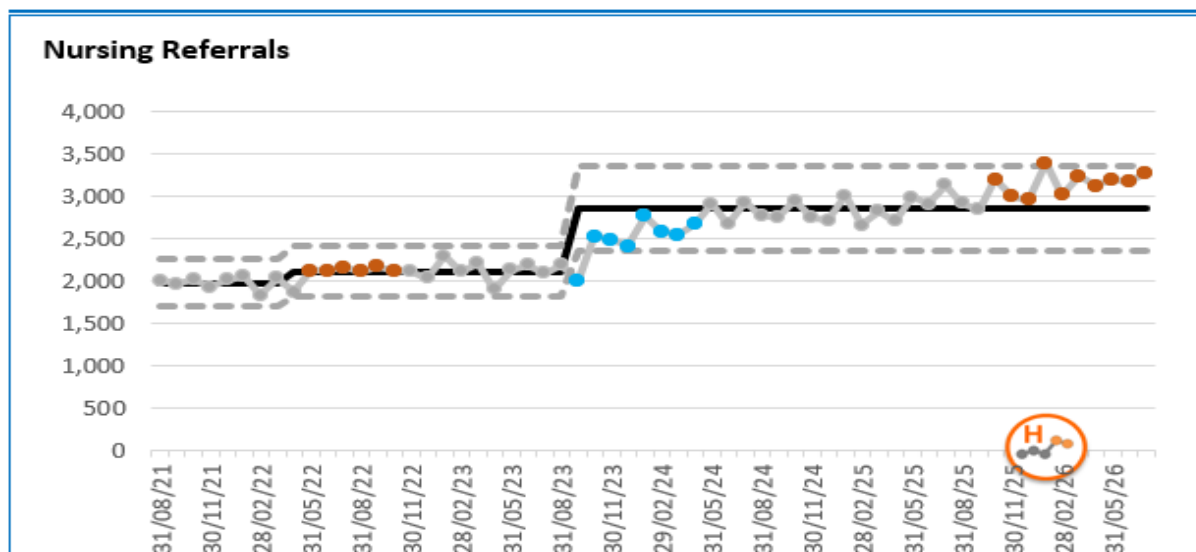


Chart 11. Community nursing referrals

The main method to manage rising demand is to risk assess visits and postpone the least urgent. Deferral or cancelling care is considered the community equivalent of corridor care. July and August data indicates 10.23% and 10.68% respectively of visits were deferred or cancelled.

Our senior nursing team have presented the robust governance for deferred visits regionally and are contributing to the national review in support of consistent reporting and guidance. Active recruitment is in place against the community staffing investment, together with sickness reductions CQI programme to support deferral reduction.

6.3 CNSST II

The combination of CNSST findings, workforce metrics, quality indicators and professional judgement provides assurance that community staffing resources are being deployed safely and effectively, but with residual risk due to increasing demand, deferred care and the time required to realise the benefits of planned investment (circa 24% vacancy).

The division is conscious that while NHSE has recommended demand and capacity tools for community nursing they do not exist for AHPs in the hospital or community, we are aware that NHSE has commissioned academic research on this, expected to be published end of next year.

Adult community nurses have completed 3 audits of the refreshed CNSST II. The summer 2026 data is being collected ready for robust triangulation of results. Once available this will feed into our 6 monthly workforce reviews.

7. Next steps / challenges

7.1 Nursing resource oversight group

The Nursing and Midwifery Deployment Group meets monthly to review best practice methods of deploying staff alongside use of temporary workers (Bank).

Total temporary spend is in special cause improvement providing assurance that temporary staffing controls and deployment oversight are having a positive impact while maintaining safe staffing oversight (Chart 12).

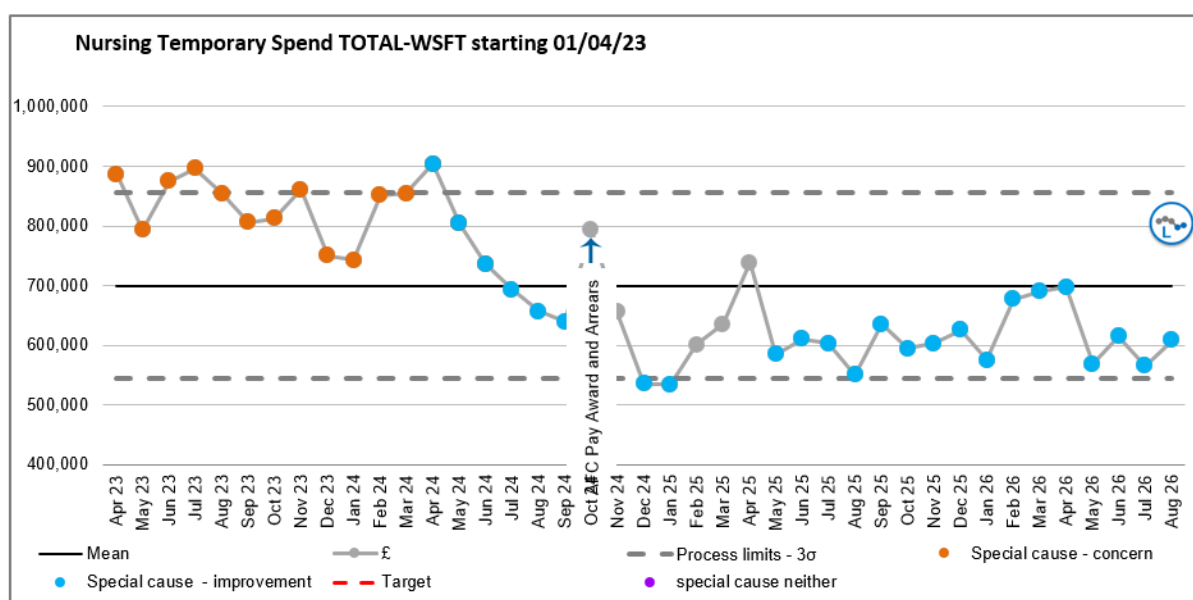


Chart 12. Total temporary spend, nursing.

7.2 SNCT Biannual inpatient review

The summer inpatient establishment census data collection was completed throughout July and August, including the Emergency Department. Analysis will continue to inform our assurance of nurse staffing levels and inform recommendations. The census will be repeated in the winter.

7.3 Newly registering student recruitment

We maintain our commitment to support newly registered nursing and midwifery colleagues to transition into the workforce and foster strong partnerships with educational institutions and system partners in line with national commitments. A recruitment plan for the 2026 qualifying cohorts has resulted in all adult nursing applicants securing a post.

8. Conclusion

The Trust continues to demonstrate a proactive and data-driven approach to nursing and midwifery workforce management, supported by strong governance, sustained improvements in registered workforce stability, and consistent quality outcomes.

The Board is asked to note ongoing residual risks in community capacity, unregistered workforce resilience and CHPPD benchmarking.

9. Recommendations

For the Board to:

- take assurance that safe staffing systems are robust and effective.
- to note ongoing residual risks in community capacity, unregistered workforce resilience and CHPPD benchmarking.

Appendix 1a. Fill rates for inpatient areas (July 2026) data adapted from NHSE Unify submission.

RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1416.25	1388	1787.25	1531.25	1069.5	1040.75	1426	1411	98%	86%	97%	99%	991	2.5	3.0	5.4
Acute Assessment Unit	2397.5	2307.833333	2047.75	1629.35	1782.5	1727.5	1426	1384.25	96%	80%	97%	97%	869	4.6	3.5	8.2
Cardiac Centre	1782.5	1447	1039	833.5	1782.5	1575.5	706.5	690	81%	80%	88%	98%	662	4.6	2.3	6.9
G10	1772	1471.283333	1783.5	1625	1069.5	1001	1782.5	1804.58333	83%	91%	94%	101%	982	2.5	3.5	6.0
G9	1777.75	1589	1416.5	1070.5	1426	1379	1069.5	1066.5	89%	76%	97%	100%	821	3.6	2.6	6.2
F12	713	732	347.5	243	708	681	356.5	272	103%	70%	96%	76%	238	5.9	2.2	8.1
F7	1560	1276.966667	1770	1563.5	1403	1162	1782.5	1591	82%	88%	83%	89%	1033	2.4	3.1	5.6
G1	1069.5	736	356.5	295	713	713	348	313.5	69%	83%	100%	90%	370	3.9	1.6	5.6
G3	1535	1345.833333	1753	1598	1069.5	1070.25	1426	1327.5	88%	91%	100%	93%	998	2.4	2.9	5.6
G4	1785.5	1490.5	1783.5	1604	1069.5	971	1426.833333	1452	83%	90%	91%	102%	983	2.5	3.1	5.6
G5	1767	1481.75	1780.5	1317.5	1058.5	994.25	1426	1430	84%	74%	94%	100%	1017	2.4	2.7	5.1
G8	2353.5	1739.333333	1862.75	1519.08333	1604.5	1532.5	1241.5	999.783333	74%	82%	96%	81%	882	3.7	2.9	6.6
F8	1762.5	1479	1747.5	1368.33333	1063.5	1006	1426	1389.5	84%	78%	95%	97%	0	-	-	-
Critical Care	2578.5	1758.25	141.25	0	2429.5	1887.75	0	0	68%	*	78%	*	183	19.9	0.0	19.9
F3	1779.5	1457	1747.5	1516	1070.5	1047.5	1426	1400	82%	87%	98%	98%	938	2.7	3.1	5.8
F4	654	820	512.5	445	621	532.5	0	160	125%	87%	86%	-	223	6.1	2.7	9.0
F5	1426	1358.416667	1416.5	1266.25	1069.5	1023.5	989	948.5	95%	89%	96%	96%	495	4.8	4.5	9.3
F6	1664.25	1431.25	1695.16667	1420.5	1046.5	1023.5	1419.5	1460.5	86%	84%	98%	103%	901	2.7	3.2	6.1
Neonatal Unit	1486	1533.5	300	444	984	984.5	600	619.5	103%	148%	100%	103%	250	10.1	4.3	14.3
F1	2190.25	1804.666667	705.25	602.75	1426	1357.25	0	80.5	82%	85%	95%	-	256	12.4	2.7	15.0
F14	372	360	372	372	744	744	0	0	97%	100%	100%	-	135	8.2	2.8	10.9
Total	33,842.50	29,007.58	26,365.42	22,264.52	25,210.50	23,454.25	20,278.33	19,800.62	86%	84%	93%	98%	13,227	4.0	3.2	7.1

* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

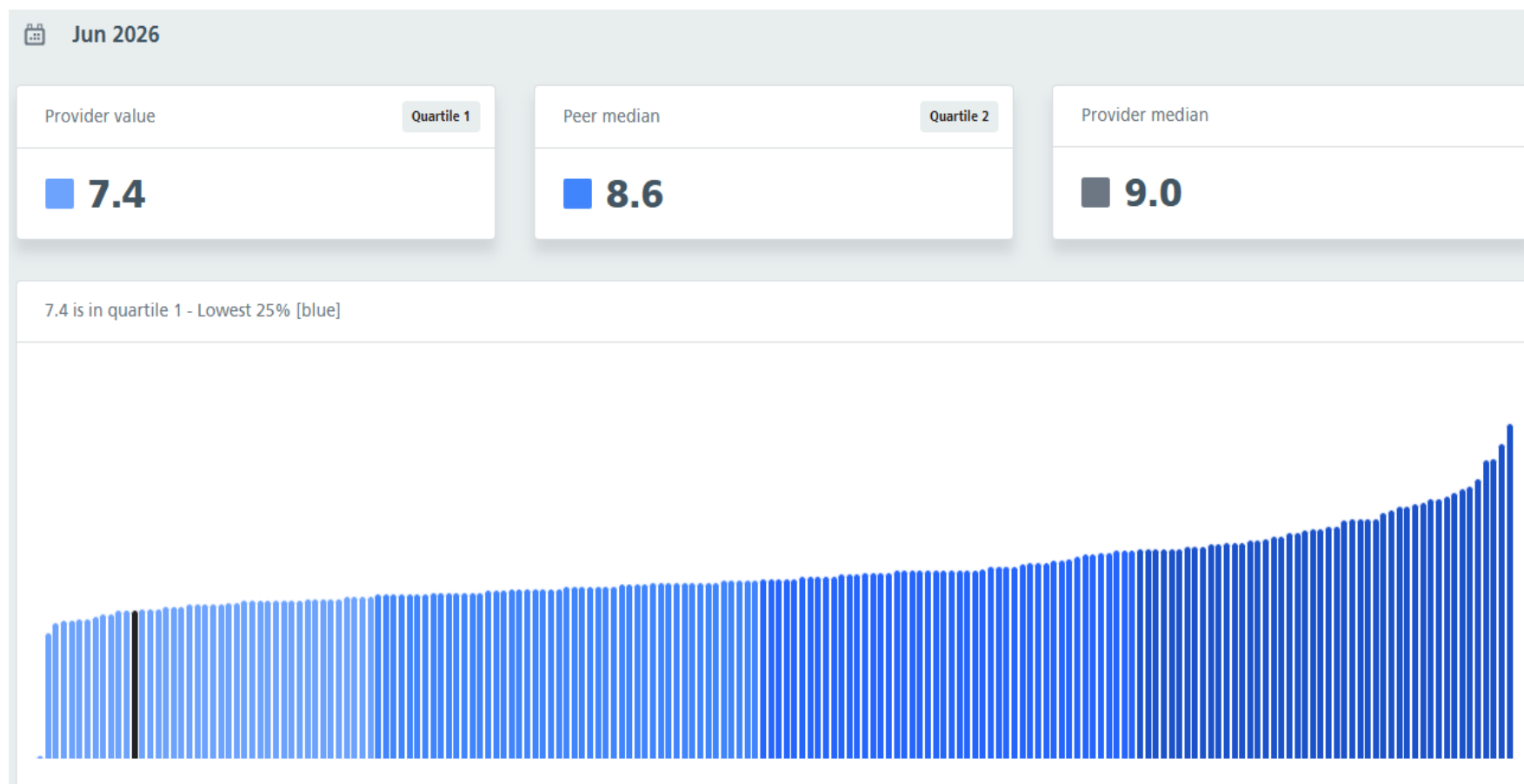
Appendix 1b. Fill rates for inpatient areas (August 2026) data adapted from Unify submission.

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1421	1346.083333	1781	1583	1069.5	1033	1426	1357	95%	89%	97%	95%	999	2.4	2.9	5.3
Acute Assessment Unit	2271.25	2223.166667	2098.58333	1606.25	1742.5	1711	1417	1359	98%	77%	98%	96%	858	4.6	3.5	8.2
Cardiac Centre	1782.5	1480.5	1060	835	1782.5	1642.75	713	653.5	83%	79%	92%	92%	674	4.6	2.2	6.9
G10	1781.5	1515.5	1783	1635.5	1069.5	966	1782.5	1727	85%	92%	90%	97%	989	2.5	3.4	5.9
G9	1781.5	1605	1428	1271.5	1426	1366	1069.5	1059	90%	89%	96%	99%	824	3.6	2.8	6.4
F12	704.5	693.75	365.5	246.75	713	662.25	356.5	332.5	98%	68%	93%	93%	236	5.7	2.5	8.2
F7	1556.25	1255.75	1776.5	1477.5	1403	1115.5	1771	1601.5	81%	83%	80%	90%	1034	2.3	3.0	5.5
G1	1062	704.5	350	327	713	690	356.5	333.5	66%	93%	97%	94%	358	3.9	1.8	5.7
G3	1506.5	1298	1738	1451.25	1046.5	1015	1371.5	1222	86%	84%	97%	89%	97	23.8	27.6	53.3
G4	1778.5	1484.75	1770.5	1589.75	1069.5	956.5	1414.5	1478.5	83%	90%	89%	105%	982	2.5	3.1	5.6
G5	1719	1432	1727	1260	1067.5	938.5	1426	1366.25	83%	73%	88%	96%	1018	2.3	2.6	4.9
G8	2461.25	1977.916667	1792	1548.63333	1541	1486.833333	1311	1056.2	80%	86%	96%	81%	867	4.0	3.0	7.1
F8	1757.5	1473.75	1806	1426.75	1070.5	963	1426	1438	84%	79%	90%	101%	767	3.2	3.7	6.9
Critical Care	2642.25	2089.25	79.25	11.5	2631.583333	2112.833333	0	0	79%	15%	80%	*	209	20.1	0.1	20.2
F3	1755.5	1545	1698.75	1396.75	1069.5	1046.5	1427	1334	88%	82%	98%	93%	879	2.9	3.1	6.1
F4	713	865	460	488.25	713	682	0	146	121%	106%	96%	*	338	4.6	1.9	6.6
F5	1393.833333	1486.583333	1386.5	1210.08333	1035	997.5	989	1010.5	107%	87%	96%	102%	475	5.2	4.7	9.9
F6	1747.166667	1531.416667	1655.25	1342.25	1023.5	976.5	1426	1403.5	88%	81%	95%	98%	902	2.8	3.0	5.9
Neonatal Unit	1533	1542	360	576	996	1001.5	660	718.5	101%	160%	101%	109%	260	9.8	5.0	14.8
F1	2159.5	1623.25	709.25	658.5	1426	1378.5	0	0	75%	93%	97%	*	177	17.0	3.7	20.7
F14	371.5	371.5	372	364	744	720	0	0	100%	98%	97%	*	117	9.3	3.1	12.4
Total	33,899.00	29,544.67	26,197.08	22,306.22	25,352.58	23,461.67	20,343.00	19,596.45	87%	85%	93%	96%	13,060	4.1	3.2	7.3

* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

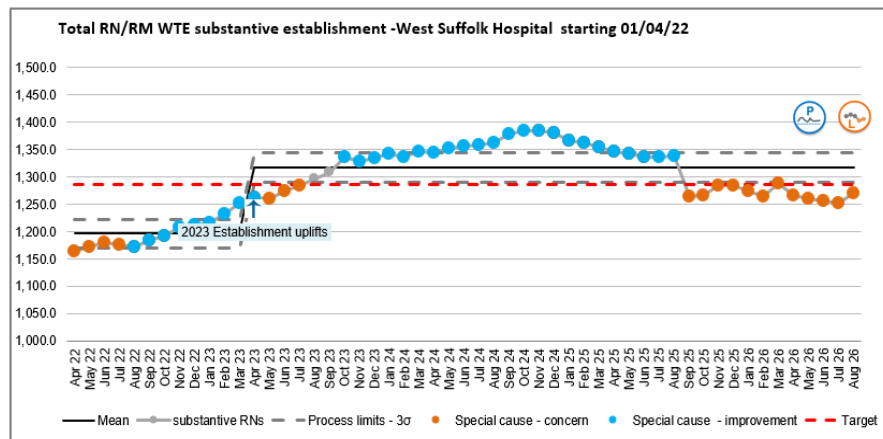
Appendix 2. CHPPD Model Hospital data (accessed 08.09.26)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1a/b). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month. CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD.

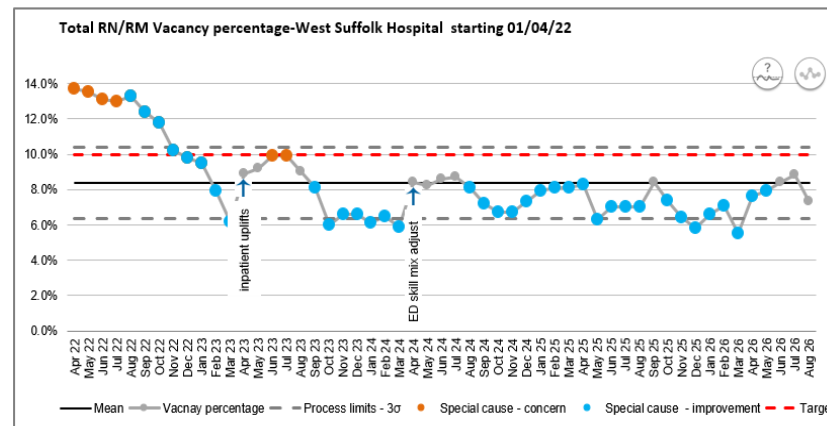


Appendix 3 WTE and Vacancy rates.

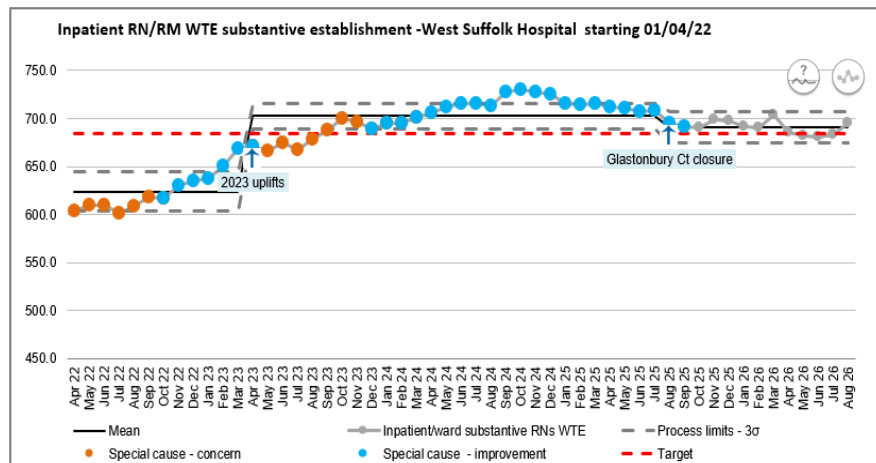
A) Trust Total RN/RM WTE



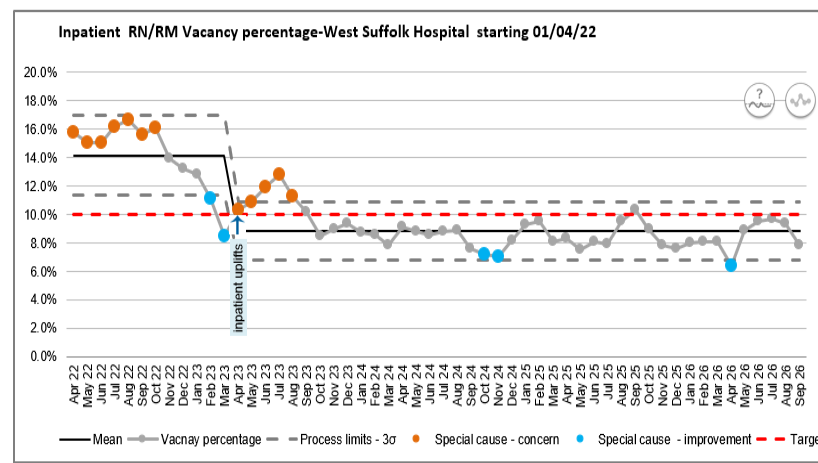
B) Trust Total RN/RM vacancy %



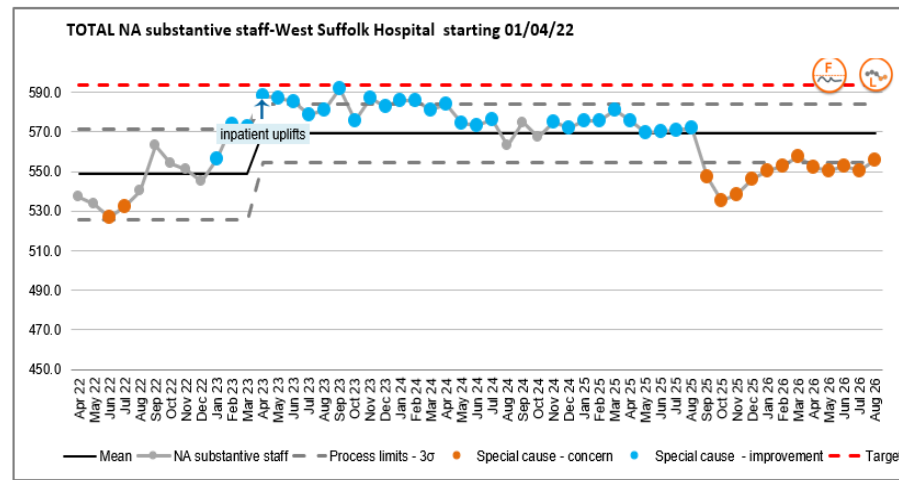
C) Inpatient RN/RM WTE



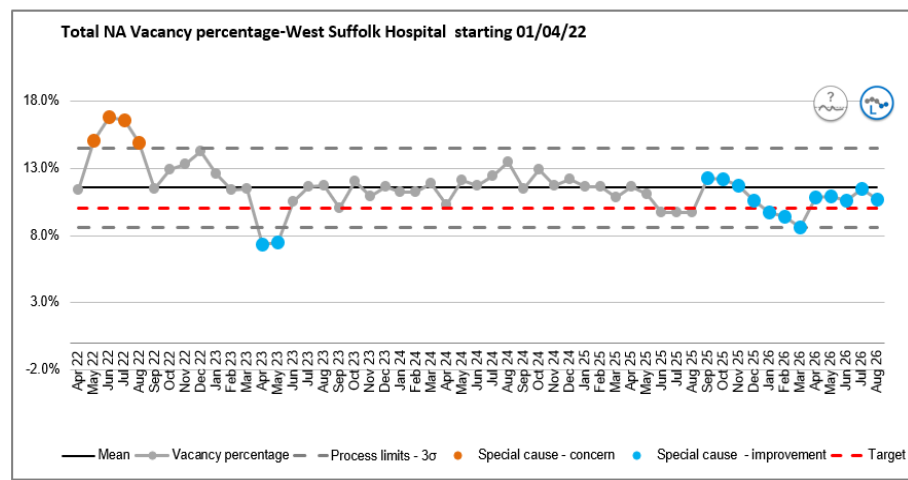
D) Inpatient RN/RM vacancy %



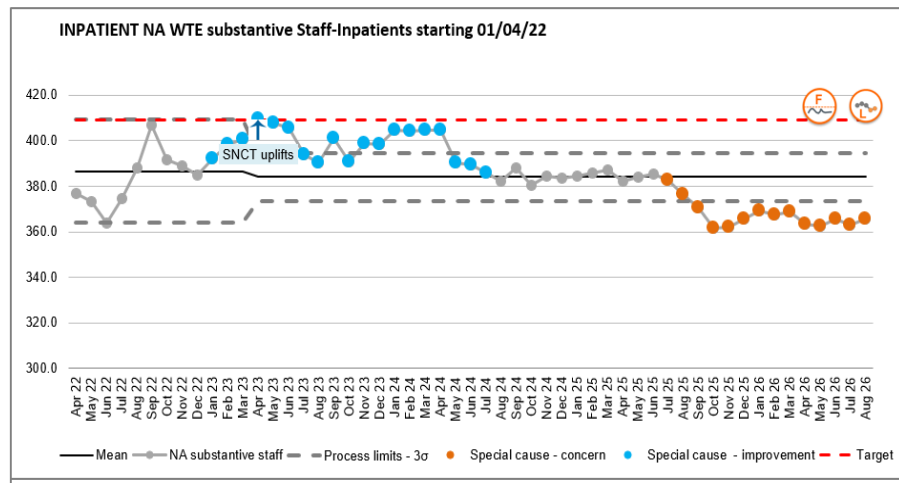
E) Total NA/unregistered WTE.



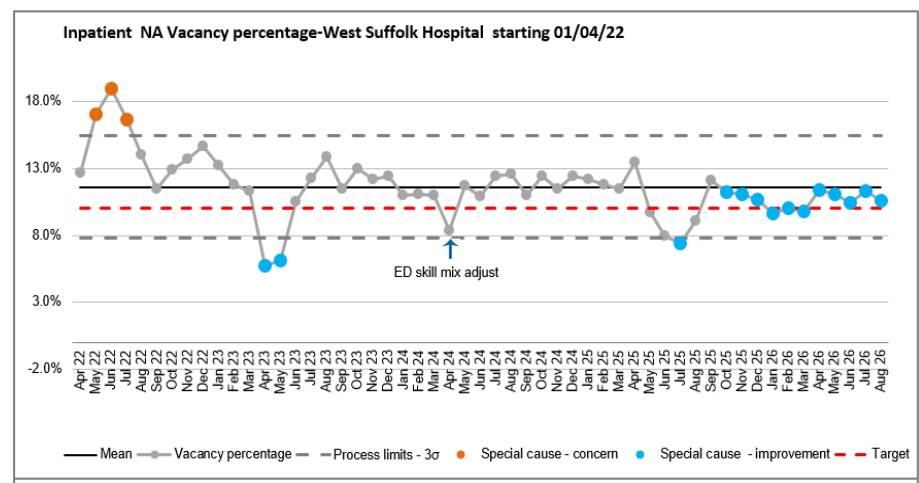
F) Total NA/Unregistered vacancy %



G) Inpatient NA/unregistered WTE



H) Inpatient NA/unregistered vacancy %



Appendix 4. Red Flag Events

Maternity Services

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool. • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration. • placement: making sure that the items a patient needs are within easy reach. • positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift.
Fewer than two registered nurses present on a ward during any shift.
Unable to make home visits.

3.4. R&D annual report (ATTACHED)

To Assure

Presented by Richard Goodwin

Meeting/committee title: (e.g. Open board; Management executive group)

Report information

Report title: Research and Development Department Update

Agenda item:

Sponsor/Executive lead: Richard Goodwin

Report prepared by: Claire Barwick

Previously considered by:

This report is for: ☐ Approval ☐ Assurance ☐ Discussion ☒ information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

This paper is to give an update on clinical research at the trust along with an update on the progress against the objectives in the enabling strategy for research.

It includes an update on national metrics as well as local initiatives within the department.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

Delivery of the objectives in the strategy are key to realising the vision of becoming a research active organisation where every patient has the opportunity to participate in high quality research.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*

Agree the metrics to be reported to the research operational committee and continue to update policies and procedures in line with national guidance.

Action required by the board: For information and discussion

Governance and compliance

Add explainer for each of the below.

Risk and assurance:

Since the pandemic the research landscape has changed significantly and is now only partially recovered. The government has consistently committed to investment in clinical research and has sought to transform the clinical research system through a raft of regulatory changes. This gives assurance that funding for NHS clinical research is not at risk.

Equality, diversity and inclusion:

There have been several studies to look at EDI in research and to ensure that at the very start of a research study when it is being written as a project that EDI is considered of the highest importance. As part of the regulatory approval process the study team now must define how they have considered EDI and why exclusions are being made in the protocol if that is the case.

Sustainability:

The objectives in the strategy have been written to ensure that the research and development department is sustainable for the future and is able to grow and develop to meet new challenges.

Legal and regulatory context:

Research is governed nationally by the Health Research Authority and the National Institute for health and care research. The research delivery team and research active staff at the trust have all completed Good Clinical Practice training through the NIHR.

Research and Development Update

1. Introduction

- 1.1. The following report provides an update and overview on the research department performance and objectives.

2. Background

- 2.1. A new strategy for research was published earlier in the year as part of the enabling strategies for the trust's main strategy.

3. Detailed sections and key issues

- 3.1. Participants recruited to research studies – There has been a stepped increase in the number of participants that the department has been able to recruit so far in 26/27 compared to the previous year. This is in part due to 1 study looking at the risks of diabetes in newborn babies. This means that the department are looking to recruit nearly twice as many participants that the previous year, around 1,000.

- 3.2. Study set up – The government announced in 2025 that by the 31st March 2026 on average all research studies would be set up within 150 days. This was broken down into 60 days for HRA (this is a sponsor target not relevant to WSFT) and other approvals 60 days for sites to set up and 30 days to recruit the first patient to the study at the site. At the time the department had an average set up time for site set up of 134 days against the target of 60 days but a 87% achievement on first patient recruited. After securing additional external funding a project has been running to focus on the reasons and the resolutions to improve the performance of the 60 day target.

After identifying a number of themes for the delays, several new processes have been put in place including standardising communications with both external sponsors and with internal clinicians. These clearly set out the expected obligations and timelines upfront. Early planning of any set up meetings and training required before a study can open are also now scheduled well in advance to allow for any changes that may be required. These measures have resulted in a 100% compliance with the 60 day target for the last 4 months.

- 3.3. Increase the number of commercial studies as well as the number of participants recruited to commercial research. This is an area where there have been challenges to move forward. There is a national system for completing expressions of interest for commercial research and we continue to ensure that we apply for all studies that are relevant for our patients and clinicians – however the conversion rate is very low at around 2%. Currently there are 2 commercial studies running, one related to CKD and one for patients with high blood pressure.
- 3.4. Feedback from patients and continuous improvement -Participants that we recruit to our research studies are asked to complete a my research experience survey at various stages of the study and the results are collected nationally. For this year we have achieved a score of 100% on the following metrics – Felt valued, treated with courtesy and respect, know how to contact research team, updated about research, would take part in research again. All other metrics were either N/A to the study or participant.

4. Next steps

- 4.1. Continue to work to the objectives above and detailed in the strategy and to provide high quality clinical research for the benefit of our patients.

5. Conclusion

- 5.1. Whilst good progress has been made on the national 60-day target there is still some areas of improvement where more focus is needed. Focus is now going to be on the 30-day recruitment target and maintaining the 60 day with new studies coming up.
- 5.2. Collaborations with other trusts in the region as well as primary care is an area that we are looking to maximise on and may allow us to be more attractive to commercial research companies. There are currently discussions with several partners that we hope to progress.

6. Recommendations

- 6.1. It is recommended that the board note the contents of this report and support the continued embedding of clinical research into everyday clinical care.

3.5. Maternity Services Report (ATTACHED)

To Assure

Presented by Karen Newbury

Meeting/committee title: Trust Board 25th September 2026

Report information

Report title: Perinatal Quality, Safety and Performance report

Agenda item: Maternity and Neonatal services –Trust Board

Sponsor/Executive lead: Richard Goodwin, Medical Director & Maternity and Neonatal Safety Champion and Dan Spooner, Chief Nurse

Report prepared by: Karen Newbury, Director of Midwifery / Nursing and Karen Green, Acting Head of Midwifery / Nursing

Previously considered by: N/A

This report is for: ☐ Approval ☒ Assurance ☐ Discussion ☒ Information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What? This report presents a document to enable board scrutiny of Maternity and Neonatal services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on quality & safety initiatives in line with the NHS Perinatal Quality Oversight Model (June 2025).

This report contains:

- Perinatal Quality Oversight Model (Annex A) – including an overview of the Sixty Supportive Steps visit by the NHSE regional Perinatal team and ICB
- Maternity and Neonatal Safety champion feedback
- Listening to staff
- Service user feedback
- Incident reporting and learning from incidents
- Training compliance for all staff groups in maternity related to the core competency framework.
- NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 8 progress

- Maternity Care Bundle implementation progress
- Reports presented to Trust Board sub committees
 - Maternity Claims Scorecard, incident and complaint data Quarterly Review Q4 25/26
 - Ockenden (Nottingham) Review and Amos Review – Implications for West Suffolk NHS Foundation Trust
- Closed Board reports;

Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints (July & August 2026)
- Next steps

So what? The report meets NHSE standard of perinatal oversight by providing the Trust board a methodical review of maternity and neonatal safety and quality.

What next? Action plans will be monitored, and any areas of non-completion will be escalated as appropriate.

Quarterly, bi-annual and annual reports will evidence the updates.

As applicable, reports will be shared with external stakeholders as required.

Action required by the board: For assurance and information.

Risk and assurance: To provide a systematic approach to the oversight of perinatal services.

Equality, diversity and inclusion: This paper has been written with due consideration to equality, diversity, and inclusion.

Sustainability: As per individual reports.

Legal and regulatory context: The information contained within this report has been obtained through due diligence.

Perinatal Quality, Safety and Performance report

1. Introduction

1.1 Perinatal Quality Oversight Model

The Perinatal Quality Oversight model (PQOM) was established in response to the need to proactively identify trusts that require support before serious issues arise, seeking to provide a consistent and methodical oversight of NHS perinatal services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. In recognition that neonatal services are interdependent with maternity services, the PQOM refer to maternity and neonatal in terms of 'perinatal'. The trust and its board ultimately remain responsible for the quality of the services provided and for ongoing

improvement. The board is supported in this by the perinatal leadership team and the Board Safety Champions. The PQOM supports trusts, Integrated Care Boards (ICBs) and Regional Teams in this duty, while providing a mechanism for escalation of any emerging risks, trends or issues that cannot be resolved at local level or would benefit from wider sharing.

An overview of the individual Trust level components of the PQOM is available in Annex A.

1.2 Safety Champion feedback

Board-level Safety Champions have been able to undertake their scheduled monthly walkabout within the maternity and neonatal units. For those not able to meet them, information regarding the Perinatal Safety Champions, including contact details, remains clearly displayed across all clinical areas to support accessibility and engagement.

A few issues have been identified through established reporting routes, including:

- Midwifery attendance at Theatre safety huddles to ensure a safe environment is provided.
- Timely response to issues, or delayed communications regarding action taken.
- Community constraints with sharing of equipment and rural working.

These issues are being actively managed, with actions and timeframes monitored through appropriate governance structures.

Board Safety Champions continue to meet with the Perinatal Leadership Team and the Maternity and Neonatal Voices Partnership (MNVP) Lead from the ICB at least bi-monthly to review progress, triangulate intelligence, and assess whether additional Trust Board support is required. Any escalations are formally recorded within the Safety Champion Action Log and are systematically monitored through the monthly Maternity and Neonatal Safety Champion meeting, ensuring robust oversight and accountability.

Role	Meeting attended;	
	14/07/26	11/08/26
Board level Safety Champion (Executive)	Apologies	✓
Board level Safety Champion (Non-Executive)	✓	✓
Perinatal Obstetric Lead/Safety champion	Apologies	✓
Perinatal midwifery Lead/ Safety Champion	✓	✓
Perinatal neonatal lead/ Safety Champion	Apologies	Apologies
Perinatal management lead	Apologies	✓
MNVP lead	Apologies	✓

An additional Board-level Safety Champion (Chief Nurse) will be attending the meetings and undertaking scheduled monthly walkabout within the maternity and neonatal units.

1.3 Listening to Staff

The maternity and neonatal service continues to promote a culture where staff feel listened to, supported, and empowered to speak up. Staff have access to a range of formal and informal feedback mechanisms, including Freedom to Speak Up Guardians, Safety Champions, Professional Midwifery and Nursing Advocates, staff forums, and dedicated focus groups.

Themes and concerns raised are reviewed and acted upon, with feedback shared openly across teams.

In early 2025, the service completed a SCORE Culture Survey as part of Wave One of the Perinatal Culture and Leadership Programme, which supports the development of a positive safety culture, psychologically safe workplaces, and compassionate leadership. The survey achieved a 49% response rate across Women's and Children's Services. Findings were subsequently explored through targeted staff engagement sessions facilitated by an external culture coach to inform ongoing improvement work.

As a result of this work, three core cultural aspirations have been identified:

OUR CULTURAL ASPIRATIONS



Develop a strong and effective communication ethos



Create a strong sense of belonging for all, across the service



Embed culture as a fundamental part of 'how we do things here'

The Perinatal Quadrumvirate, supported by the Trust's in-house Culture Coaches, continues to lead improvements in safety culture and progress these aspirations. Examples of work underway include:

- 'Civility Saves Lives' and 'Active Bystander' conversations with staff undertaken by the Perinatal Quadrumvirate.
- Face to face discussions regarding the Amos National Maternity Review and Ockenden (Nottingham) report publication, to give an overview of the reports, immediate action to be taken and where staff can access support due to the nature of the reports and subsequent targeted social media posts.
- Reverse Mentoring and Sponsorship: Due to low numbers of uptake, this programme was not viable.
- Launch of the National Perinatal Equity and Anti-Discrimination Programme – WSFT perinatal leadership team and 7 clinical leaders due to commence January 2027.
- Snapshot perinatal nursing and midwifery staff survey results were shared with perinatal teams in July 2026. The survey findings provided a valuable insight into the lived experience of nursing and midwifery staff and provided an opportunity for them to share solutions to any issues. While positive themes relating to teamwork, flexibility

Compassionate care,
 healthier communities

and professional pride were evident, concerns regarding culture, staffing pressures and leadership responsiveness require further attention. A targeted improvement plan is in progress and oversight will be part of the established governance process.

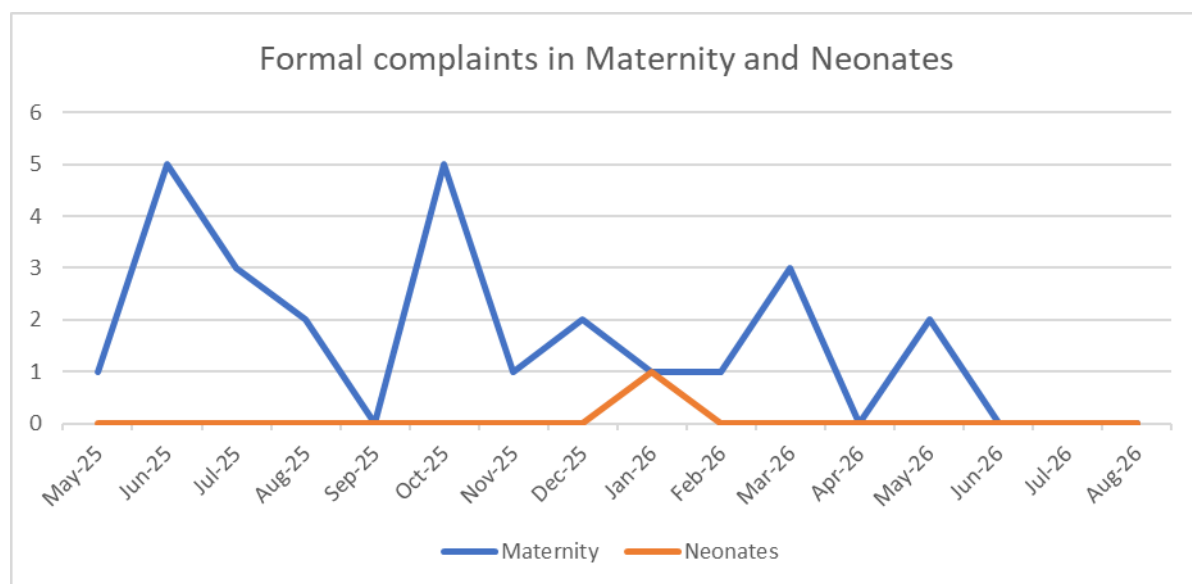
1.4 Service user feedback

Service user feedback plays a vital role in healthcare by providing direct insight into the quality of care received. It enables providers to make meaningful improvements by enhancing care standards, improving patient experience, and driving innovation. When patients share their experiences, they highlight strengths and identify gaps in service delivery that may otherwise go unnoticed.

To support this, the NHS introduced the Friends and Family Test (FFT). This simple, anonymous tool helps providers and commissioners understand patient satisfaction and identify areas where improvement is required. It offers an accessible way for patients to share feedback following NHS care or treatment.

Complaints and Learning

Formal complaints remain an important source of organisational learning and service improvement. During this reporting period the maternity and neonatal service have not received any complaints.



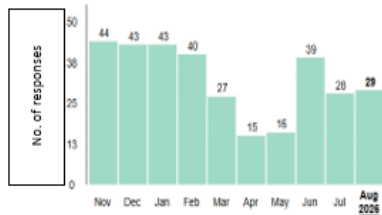
No complaints have been received on this reporting period, no complaints have been concluded and there are no open complaints.

Friends and Family Test (FFT)

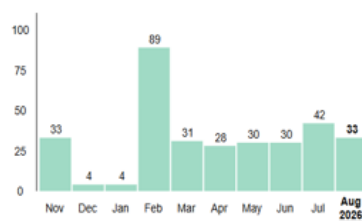
FFT responses continue to be monitored across all maternity and neonatal services; however, achieving high response rates remains challenging. Evaluation of F&F accessibility

has taken place. While there are some challenges great effort is made to gain feedback. The Patient Experience Midwife is exploring the text alert service to increase the uptake.

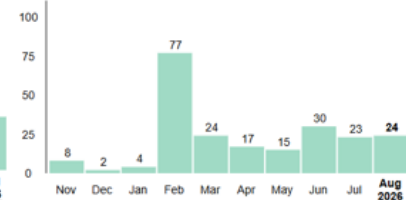
Inpatient Maternity (Birth)



Antenatal



Postnatal



Patient Experience Reported by Service Users

Ward/Dept	July- All completed	July Positive Response	Aug – All completed	Aug- Positive Response
Inpatient Maternity	28	100%	29	100%
Community Antenatal	33	88%	25	85%
Community Postnatal	24	91%	23	80%

Most women who responded to the FFT rated their care as Good or Very Good across all areas of the service: Antenatal services received positive ratings of 88% in July and 85% in August, with community postnatal services achieved positive ratings of 91% and 88%. Feedback from F11 remained largely positive, although there was a reduction in the proportion of women selecting "Very Good" during August. Labour care continued to attract very positive feedback, with all respondents rating their experience as Very Good during the reporting period.

Whilst response rates remain low and cannot be considered representative of the experience of all women accessing maternity services, the data provides valuable insight when considered alongside other sources of patient feedback and service intelligence.

Across all feedback sources, women consistently recognised the kindness, professionalism, and commitment of maternity staff. This remains a significant strength of the service and is evident even within feedback where women describe concerns about aspects of their care. Women frequently distinguished between their positive interactions with staff and the operational challenges affecting the wider service.

A notable finding is that women tend to describe their experience as a single maternity journey rather than as interactions with individual teams. Community feedback frequently referenced experiences relating to induction of labour, scans, fetal medicine, labour care and postnatal services, reinforcing the importance of considering patient experience from a whole-pathway perspective.

The most consistent themes identified through both FFT and PALS were communication, coordination of care and continuity. Women described occasions where they received differing advice, experienced appointment changes or delays, had to seek updates regarding their care, or felt required to coordinate aspects of their own journey. PALS contacts reflected similar concerns, particularly regarding appointment scheduling, administrative processes and understanding of care plans. Whilst numbers were small, the consistency of these themes across multiple sources suggests opportunities to further strengthen communication and coordination across the maternity pathway.

Continuity of care also featured regularly within the feedback. Women described the value of seeing familiar professionals and developing relationships with those involved in their care, particularly during complex pregnancies and the postnatal period. Whilst current workforce pressures can make continuity difficult to achieve consistently, the feedback reinforces the importance women place on feeling known, listened to and supported throughout their maternity journey.

Feedback relating to postnatal care, particularly on F11, was more mixed. Some women described delays in receiving support, feeding advice, emotional support and information following birth. Similar themes were reflected within a small number of PALS contacts, particularly from women who had experienced complex births, neonatal admissions, or challenging postnatal recoveries.

Recent audit work provides important context to these experiences. An audit of postnatal transfer times demonstrated that women frequently remain on Labour Suite considerably longer than the locally agreed transfer standard, often receiving ongoing postnatal support and recovery. Midwives reference the importance of facilitating privacy during the first few hours following birth. Conversely, a review of transfer times for women awaiting artificial rupture of membranes identified that Labour Suite acuity, capacity and staffing pressures contribute to delays within induction pathways. These findings correlate with patient feedback describing delays associated with induction and prolonged waiting periods for progression of care.

When considered together, these findings highlight the complexity of balancing individual patient experience with overall maternity flow. Women who remain longer within Labour Suite and birth areas may benefit from additional support and recovery time immediately following birth; however, this can reduce capacity for women awaiting induction or transfer into Labour Suite. The challenge for the service is therefore not simply reducing delays in one area but achieving the right balance across the pathway so that improvements for one group of women do not unintentionally impact the experience of another.

Social Media

Social media continues to provide an additional source of patient engagement and insight. Whilst feedback cannot be captured systematically through these platforms, engagement between maternity and neonatal services and service users remains strong.



July



August



Data demonstrates nearly half a million views and 6000 interactions on social media with service-related posts during this reporting period. These posts provided advice and information relating to health, education, labour and birth, and wider maternity and neonatal topics. This is a powerful tool to communicate with service users and to provide positive messages about the maternity service here at WSFT.

Birth Reflections

The Birth Reflections Service continues to provide valuable insight into women's experiences of maternity care and supports organisational learning through a greater understanding of how care is experienced by women and families.

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During this reporting period, 34 women attended appointments with the Birth Reflections Service, representing full utilisation of all available appointments. The service is maintained through two dedicated senior midwives facilitating appointments in 7.5 hours per week (shared).

Themes identified through Birth Reflections are consistent with wider patient experience feedback and include frustration with delays within the induction of labour pathway, concerns regarding pain management during induction and the latent phase of labour.

Women who have their labour induced are overrepresented in those seeking support through the birth reflections service, as are women who birth by an unanticipated caesarean section. The most common reason for women accessing birth reflections is to understand a timeline of events as they struggle to recollect details. Women who birth vaginally without the need for instrumental assistance, access the service less frequently than any other group.

Birth Reflections continues to provide an important opportunity to identify improvements in communication, expectation-setting and personalised care, whilst also recognising the high standard of clinical care and support provided by maternity teams.

1.5 Incident reporting and learning from incidents

The table below demonstrates referrals to the Maternity and Neonatal Safety Investigation (MNSI) programme and the number of reported patient safety incidents.

	July 26	August 26
No. of MNSI referrals	0	0
No. of Patient safety incidents	109	91

It is important to note that not all reported incidents reflect adverse outcomes or omissions in care delivery. National and regional guidance actively promotes the reporting of maternity triggers to strengthen transparency and standardisation in safety monitoring. Ongoing surveillance continues to identify any emerging themes and ensure timely action is taken to mitigate potential risks.

The perinatal service is represented at the Norfolk and Suffolk ICB safety forum, where incidents, reports and learning are shared across all five maternity units.

Quarterly reports are shared with the Trust Board to give an overview of any cases, with the learning and assurance that reporting standards have been met to MNSI/Early Notification Scheme and the Perinatal Mortality Review Tool (PMRT).

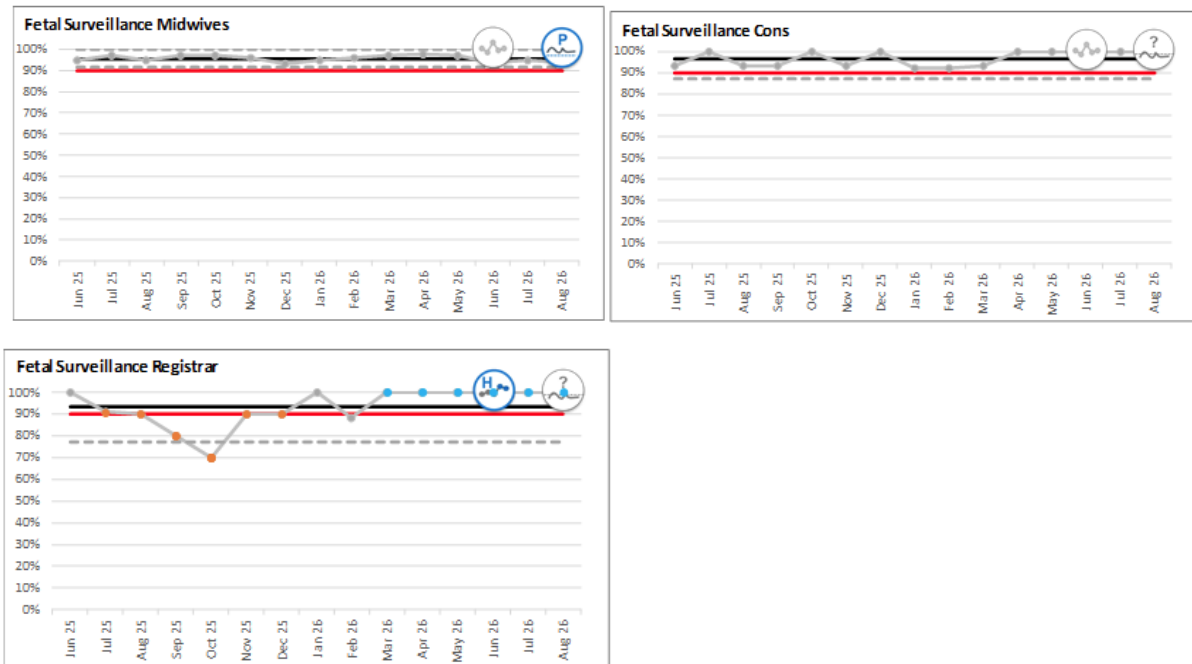
1.6 Training compliance for all staff groups in maternity related to the core competency framework

SPC charts demonstrate sustained compliance with the key elements of the Core Competency Framework, despite ongoing changes to national training requirements. Compliance is closely monitored, with any gaps addressed promptly through targeted training and development opportunities.

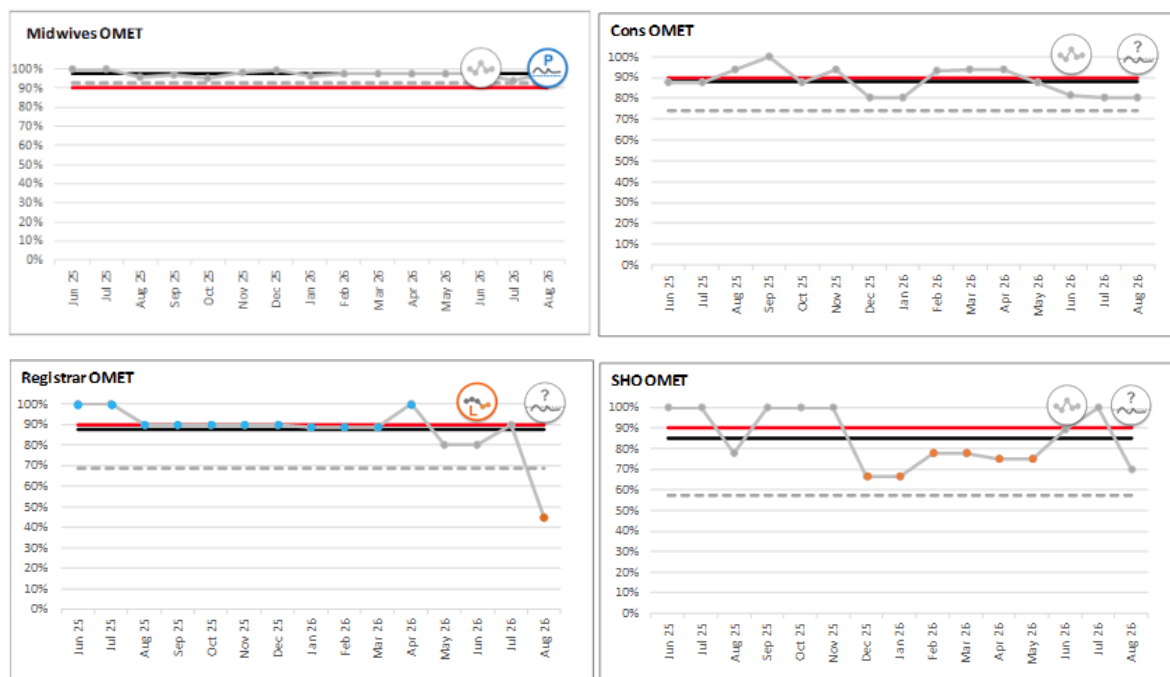
Maintaining full compliance can be particularly challenging within smaller professional groups and rotational medical staffing cohorts, where non-compliance often relates to a small number

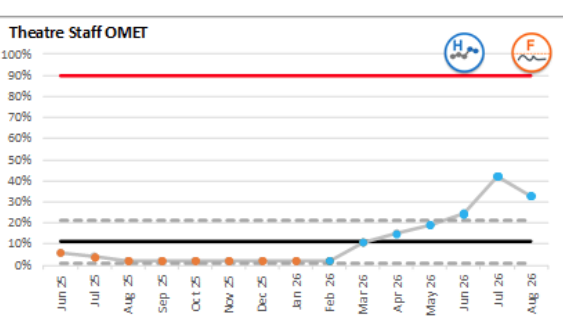
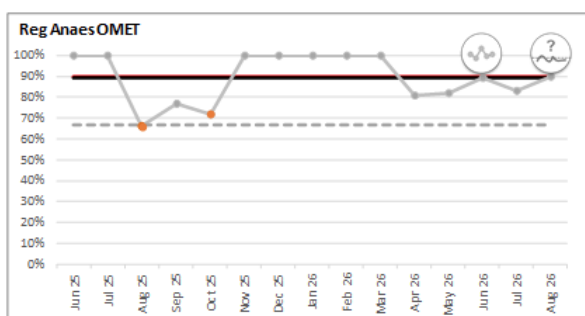
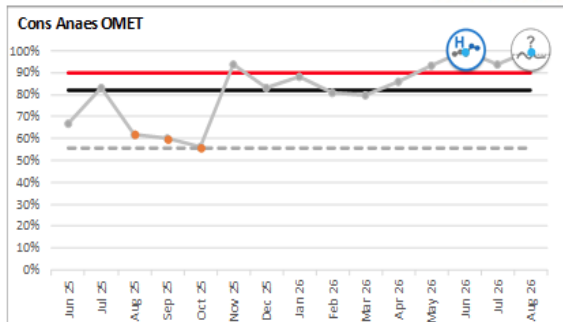
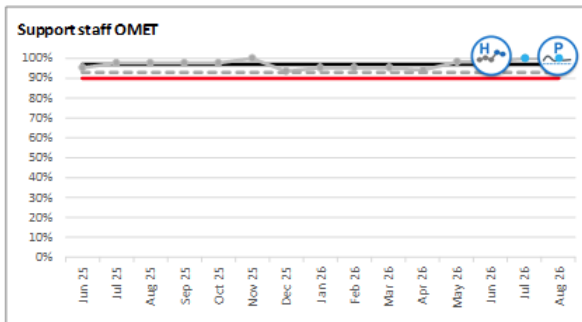
of individuals. Monitoring arrangements are in place to minimise training lapses and support timely completion. The decrease in compliance recorded in August is an anticipated consequence of the arrival of a new cohort of resident doctors. This represents a temporary position during the induction period, with compliance expected to improve as mandatory training is completed.

Fetal monitoring training

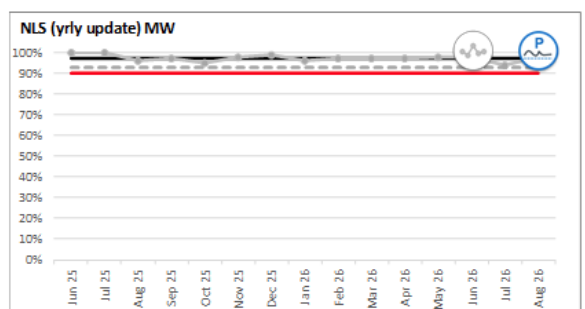
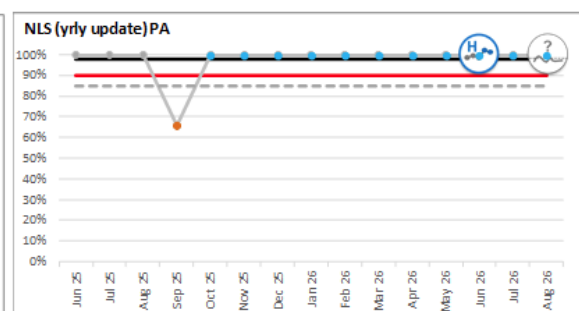
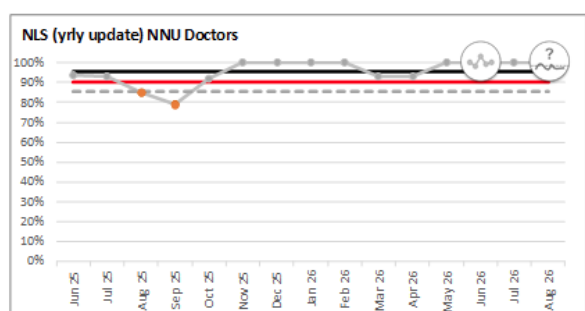
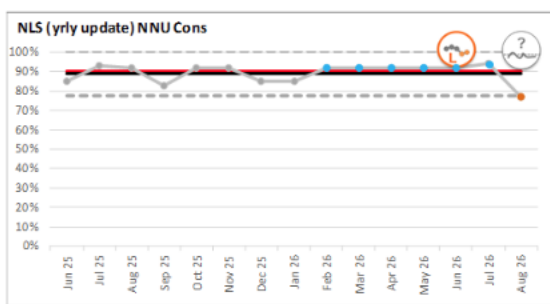
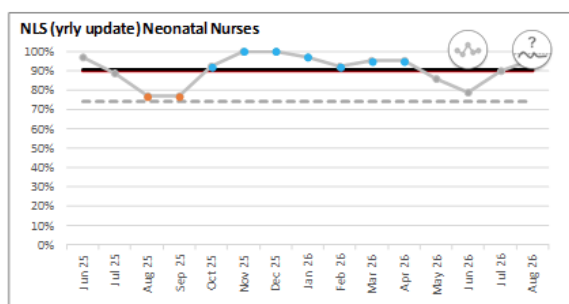


Multi-professional maternity emergency training (OMET)





Neonatal resuscitation training (NLS)



1.7 NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 8 progress

Now in its eighth year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care and reduce avoidable harm.

Year 8 of the scheme was launched in April 2026, with the reporting period 1st April until 30th November 2026, for submission by the 2nd March 2027. This year the number of safety actions have reduced to six, however it requires whole-system engagement from Board to frontline, with increasing scrutiny on credible evidence, culture, and demonstrable improvement rather than compliance alone.

The new safety actions are as follows.

Safety Action	Description	Number of domains in each safety action
A	Workforce and capacity	7
B	Training	5
C	Learning from reviews and investigations	6
D	Service-user voice and equity	2
E	Care bundles (Saving babies lives & maternal)	3
F	Board oversight, governance, culture and leadership	4

The service is actively implementing the new requirements and is on track to achieve full compliance with all six safety actions.

1.8 Maternity Care Bundle implementation progress

The Maternal Care Bundle (MCB) is a nationally mandated programme that sets out evidence-based best practice standards across five key areas of maternity care. Its overarching aim is to reduce maternal mortality and morbidity, while addressing the inequalities that contribute to adverse maternal outcomes. This first version of the MCB establishes a baseline framework for care in clinical areas associated with higher rates of maternal harm, supporting greater consistency, safety and quality across maternity services. All NHS trusts providing maternity services, alongside Integrated Care Boards (ICBs), are required to achieve full implementation of the MCB by March 2027, ensuring that these standards are embedded across maternity pathways and contribute to improved outcomes for women and their families.

The table below provides an overview of our current position of full implantation.

Element	Progress	Summary
1: Venous thromboembolism	3/5 core components achieved	Plan to go live in October 2026 with the 2 remaining core components

2: Pre-Hospital and Acute Care	7/12 core components achieved. 2/12 core components sat with Regional Team	MEWS has gone live in Maternity and Gynae and will be rolled out across the Trust by the CCOT. Signage has been ordered for directing Ambulance service to the Labour Suite. On track for full implantation by March 2027. 2 out of the 12 components sit with the regional team in regard to training and annual audits of the Maternal Medicine Networks and therefore are out of the control of maternity services.
3: Epilepsy in pregnancy	3/7 core components achieved. The outstanding components will go live from October.	Plan to go live in October 2026
4: Maternal Mental Health	2/4 components achieved.	Digital component is a long-term goal with a short-term manual work around. Plan to go live in October.
5: Obstetric Haemorrhage	5/6 components achieved	Outstanding component (TEG machine in theatre) in progress and on track for completion by March 2027.

2. Reports

2.1 Reports approved by the Trust Board sub-committees

NHS Resolution's revised Maternity Incentive Scheme (MIS) requirements introduced changes to Trust governance and assurance arrangements in 2024. This has provided an opportunity to streamline reporting structures and strengthen oversight, ensuring that each safety action receives appropriate scrutiny and approval through the relevant governance forums.

Assurance reporting is undertaken at defined intervals throughout the year, ranging from monthly to annual reviews, with many processes embedded within routine service governance arrangements. This supports continuous monitoring and improvement beyond the annual MIS reporting cycle.

The revised governance framework, approved by the Trust Board in May 2024, includes delegated oversight and approval of specific reports through Board sub-committees, providing robust assurance while maintaining clear accountability for compliance with MIS requirements.

Reports presented and approved at the Quality and Patient Safety Committee held on;

15th July 2026:

1. Ockenden (Nottingham) Review and Amos Review – Implications for West Suffolk NHS Foundation Trust.

19th August 2026: No reports were due to be presented.

16th September 2026:

1. Maternity 10 Point Plan – Board sign-off
2. Maternity Triage specification Benchmarking Audit Tool Dashboard – Board sign-off
3. Perinatal workforce report October 2025-March 2026, including Elective Caesarean Section demand and capacity review.

2.2 Reports for CLOSED BOARD

Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.

1. Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints (July & August 2026)

The paper demonstrates that statutory and scheme requirements are being met, while triangulated intelligence identifies recurring themes requiring continued Board oversight:

3. Next steps

Reports will be shared with the external stakeholders as required.

Action plans will be monitored and updated accordingly.

4. Conclusion

The Board can be assured that it continues to receive appropriate and comprehensive oversight of perinatal services in accordance with the national Perinatal Quality Oversight Model. The governance structures, reporting mechanisms, and quality assurance processes in place provide the Board with clear visibility of performance, risks, and improvement activity. Collectively, these arrangements offer the required assurance that our perinatal services remain safe, well-governed, and focused on delivering high-quality care for women, babies, and families.

5. Recommendations

It is recommended that the Board note the content of this report and support the continued application of the established governance and oversight processes for perinatal services.

Annex A

Perinatal Quality Oversight Model Data Measures

Metric	Frequency to be shared with board	Where evidence will be presented
1. Findings of review of all perinatal deaths using the real time data monitoring tool with actions	Quarterly	Closed board- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
2. Findings of review of all cases eligible for referral to Maternity and Newborn Safety Investigations (MNSI) programme with actions	Quarterly	Closed board- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
Report on: 2a. themes and actions from patient safety incidents	Quarterly	Closed Board - Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
2b. training compliance for all staff groups in maternity and neonatal critical care related to the core competency framework and wider job essential training (%)	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
2c. minimum safe staffing in maternity and neonatal services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing. Planned cover versus actual	Bi-annual	People and Organisational Development Committee – overarching perinatal services workforce paper.
3. Service User Voice Feedback - Themes	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
4. Staff feedback from frontline champion and walk-about – themes	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
5. Maternity and Newborn Safety Investigations (MNSI) programme, NHS Resolution, Care Quality Commission (CQC) or other organisation with a concern with or request for action made directly to the trust	As applicable	Closed board- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
6. Coroner Reg. 28 made directly to trust, where applicable	As applicable	Closed board- Maternity Quality and Safety Themes and Learning Report: Claims, Incidents and Complaints
7. Progress in achievement of Maternity Incentive Scheme Safety actions	Bi-monthly	Open board- Perinatal Quality, Safety and Performance paper
8. Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Annual	Open board- Perinatal Quality, Safety and Performance paper
9. Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (reported annually)	Annual	Open board- Perinatal Quality, Safety and Performance paper

4. EMPOWERED TO IMPROVE

4.1. People & Organisational Development Committee - Committee's Key Issues (ATTACHED)

To Assure

Presented by Heather Hancock

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
4.0	Recent announcements affecting workforce National workforce and policy updates –	Partial	Engagement with the new Secretary of State indicates, at present, no material change to current NHS plans No material change to current Trust plans. Consultant industrial action remains a potential workforce risk. Lord Mann update: Most actions have progressed. One area remains outstanding relating to the potential adoption of a formal definition of antisemitism. The Trust is awaiting further national guidance	Continue delivery of current plans Monitor industrial action and any local impact; Await national guidance on the outstanding Lord Mann action.	Assure Inform/Assure Alert /Assure	No escalation. Continue monitoring national developments and escalate only if there is a material local workforce, operational or policy impact. Board to remain sighted; final decision to return through appropriate governance route.

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
			before reaching a final position.			
4.4	Staff Pulse survey Staff pulse survey response rates and overall scores have declined compared with previous periods. Key themes include communication, workload, resourcing, recognition and simplifying processes. Awareness of the Trust strategy has improved. Further analysis of free-text feedback is underway	Partial	The downward trend in staff experience, alongside recurring concerns about workload, communication and organisational processes, requires attention. Improved understanding of Trust strategy is encouraging but has not yet translated into improved overall staff experience.	Complete analysis of staff comments, identify priority actions and accountable leads, and use the findings to inform the NHS Staff Survey response. Monitor improvement through subsequent pulse survey results.	Alert Assure	Board oversight required
5.1	My Wish Maternity Service Charitable investment is delivering clear additional benefit to patients and families and demonstrates effective partnership working between My WiSH, clinical teams and Quality Improvement.	Substantial	Charitable investment is delivering clear additional benefit to patients and families and demonstrates effective partnership working	Continue to strengthen impact measurement, share learning and patient stories, and ensure funding remains focused	Assure	No escalation required. Board to note the positive impact and contribution

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
			between My WiSH, clinical teams and Quality Improvement.	on areas of greatest benefit.		of My WiSH and associated fundraising.
6.1	Update on Mandatory Learning The Trust remains compliant with current national mandatory learning requirements, with strengthened governance now in place for approving additional mandatory training. The new national framework is awaited.	Partial	The Committee received assurance that current requirements are being appropriately governed and that additional mandatory learning is subject to greater scrutiny, helping manage unnecessary training burden.	Review and implement the new national framework when published and assess any resulting changes to Trust requirements	Assure /Inform	No escalation required. Committee to oversee implementation of the new framework and escalate any material compliance or workforce impact.
5.4	The National Leadership and Management Framework This has been launched, introducing common standards, competencies and self-assessment for NHS leaders and managers. A Trust SLT pilot is	Partial	This provides an opportunity to strengthen leadership capability and consistency across the Trust. The key risk is that implementation becomes compliance-led rather	Complete the pilot, identify capability and development gaps, align Trust leadership and appraisal processes to the framework, and agree	Assure/ inform	No escalation Committee to oversee implementation and receive further assurance

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	underway ahead of wider implementation by the end of Q4.		than driving meaningful development and behavioural change. Alignment with appraisal and existing leadership programmes will therefore be important	measures of impact before wider rollout.		on identified capability gaps, progress and agree measures of impact.
6.4	Gender disability and ethnicity pay gap report Annual Gender, Disability and Ethnicity Pay Gap Reports identify continuing disparities across the workforce. Action plans are in place, but the Committee requested greater clarity on the evidence underpinning some conclusions, particularly around recruitment outcomes and potential bias	Partial	There is clear evidence of workforce inequality, but understanding the underlying drivers is essential if the Trust is to target interventions effectively. The Committee requires assurance that actions move beyond reporting and result in measurable improvements in representation,	Strengthen the analysis, clearly distinguish evidence from interpretation, identify the principal drivers of the pay gaps, and tighten accountability and measures for the associated action plans. Report progress and impact back to Committee.	Alert/Assure	2. Committee to maintain close oversight. Further assurance required on the robustness of the analysis and effectiveness of actions; escalate if disparities persist without measurable improvement.

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
			progression, retention and staff experience.			
6.5	WRES/WDES reports The annual WRES and WDES reports identify continuing inequalities in staff experience. Key areas of concern include recruitment, bullying and harassment, anti-racism, disability inclusion and confidence in disability disclosure. Action plans are in place, but some WDES measures have deteriorated.	Partial	There is evidence that some staff groups continue to experience poorer outcomes and, in some areas, the position is worsening. The critical issue is whether current actions are creating meaningful behavioural and cultural change, particularly in relation to psychological safety, inclusion and confidence to raise concerns or disclose disability.	Strengthen delivery and accountability for WRES/WDES actions, with measurable outcomes focused on recruitment, bullying and harassment, disability disclosure and workplace support. Review the ethnicity narrative for evidence and context, and monitor whether staff experience improves.	Alert /Assure	1. No escalation

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
6.6	Inclusive Culture Policy The Inclusive Culture Policy is moving into implementation, with focus on respectful behaviours, support for staff experiencing bullying, harassment or discrimination, and clearer reporting and escalation routes. Further work is also underway on communicating expected behaviours to patients, carers and visitors.	Partial	The policy is in place, but the key test is whether staff and managers can easily understand and use it in practice. Effective implementation is important to creating a safer, more respectful culture and ensuring inappropriate behaviours are addressed consistently.	Simplify practical guidance and signposting, strengthen links to reporting and support routes, communicate behavioural expectations more widely, and monitor evidence of behavioural and cultural change. Await national guidance on gender identity and facilities before changing local arrangements.	Assure/Inform	No escalation at present. Committee to retain oversight and seek evidence that implementation is improving staff confidence, consistency of response and organisational culture.
7.1	Parent and Carer Network A significant proportion of the workforce reports parent or wider caring responsibilities, but engagement with the Parent and Carer Network remains relatively small at around 40members. The network is developing support around flexible working, returning from maternity leave, breastfeeding and manager guidance.	Partial	Caring responsibilities potentially affect a large proportion of the workforce and may have implications for staff experience and retention. The opportunity is therefore bigger than the network itself: the Trust	Increase the network's visibility and reach, develop practical manager and return-to-work support, and use workforce and exit data to identify where caring responsibilities are contributing to retention or	Assure /inform	No escalation at present. Committee to receive further assurance on reach, identified workforce barriers and evidence that actions are

Originating Committee: People Organisation & Development			Date of meeting: 19 th August 2026			
Chaired by: Heather Hancock			Lead Executive Director: Julie Hull			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
			needs to understand whether its working practices enable staff with caring responsibilities to remain and thrive at work.	staff-experience issues. Align governance with organisational priorities.		improving the experience and retention of staff with caring responsibilities.
8.1	Reasonable	Reasonable	Reduced appraisal compliance limits assurance that staff are receiving regular performance, development and wellbeing conversations. Although system implementation is a contributory factor, continued deterioration would indicate a wider management and workforce risk.	Resolve ESR access issues, implement a clear recovery plan for appraisal completion and monitor progress through future IQPR reporting	Alert/Assure	1 Committee to receive further assurance on recovery actions and timescales. Escalate if ESR issues remain unresolved or appraisal compliance fails to improve.

*See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence...	Further consideration...
 What? Deepening understanding of the evidence and ensuring its validity	Validity – the degree to which the evidence... • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
 So what? Increasing appreciation of the value (importance and impact) – what this means for us	Value – the degree to which the evidence... • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
 What next? Exploring what should be done next (or not), informing future tactic / strategy, agreeing follow-up and future evidence of impact		• Recommendations for action • What impact are we intending to have, by when and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

Definitions

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	Inform	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	Assure	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

4.1.1. Gender, disability and ethnicity pay gap - (ATTACHED) (+Appendices)

Presented by Sarah Hodds

Open Board

Report information

Report title: Disability pay gap report 2025-2026

Agenda item: -

Sponsor/Executive lead: Sarah Hodds, Interim chief people officer

Report prepared by: Jamais Webbsmall-Eghan, Head of inclusion

Previously considered by: Workforce wellbeing and inclusion group (June 2026), People, culture and organisational development committee (August 2026)

This report is for: ☒ Approval ☒ Assurance ☐ Discussion ☐ information

This report supports the following ambitions within the organisational strategy:

- ☐ High quality care ☐ Joined up services
- ☒ Empowered to improve ☐ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

Our data shows a mean pay gap of 6.11% between disabled and non-disabled colleagues. This means that for every £1 the average non-disabled person earned, the average disabled person earned £0.94.

There is also a median pay gap of 7.63%, which means that for every £1 the median non-disabled person earned, the median disabled person earned £0.92. The mean and median pay gaps between disabled and non-disabled colleagues have reduced since 2024-2025, which were 7.44% and 8.75%, respectively.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

In addition to the pay gap that has been identified, there are two significant barriers within this area of work. These are as followed:

1. High 'non-disclosure' rates: although disability disclosure via ESR has improved over the past year, there remains to be a large percentage of our colleagues who have not shared or updated their disability EDI information the organisation through ESR or selected options such as 'undeclared'.
2. There are multiple, conflicting options on ESR for colleagues to select from. This is a barrier preventing the streamlining and accurate interpretation of our data.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*

Actions have been identified to address the disability pay gap within our organisation. This contributes towards our wider work and commitment to enhance disability inclusion and equity within our Trust.

Action required by the Group:

- Review the data presented within the report. Ensure that it has been analysed fully and the narrative within this report is informative, clear, and accessible for all.
- Note the actions within the pay gap action plan. The pay gap action plan contains actions to address the gender, ethnicity and disability pay gaps within the Trust. Many of these are existing actions or actions that have evolved as the result of ongoing work.
- Approve the report and the pay gap action plan for internal and external publication

Governance and compliance

Risk and assurance: This is the second year that the Trust has produced its Disability Pay Gap (DPG) report. Reporting on the DPG is a requirement of High Impact Action 3 within the NHS EDI Improvement Plan, which focuses on identifying pay gaps and implementing improvement plans to eliminate them.

Equality, diversity and inclusion:

Taking action to understand and address our disability pay gap is one of the areas we are firmly committed to as we continue to work towards our ambition of fostering an equitable and inclusive organisation where disabled colleagues can progress, thrive and feel recognised and valued.

Sustainability: n/a

Legal and regulatory context:

As an employer with more than 250 employees, WSFT is required to report its Gender Pay Gap data every year by 31 March.

At this current time, reporting on the DPG is not a statutory requirement. This will change in due course (the exact timeline is currently unclear) as the Government has committed to introducing mandatory ethnicity and disability pay gap reporting for organisations with more than 250 employees.

Disability Pay Gap Report 2026

1. What is the disability pay gap?

The disability pay gap (DPG) looks at the difference in the average hourly pay between disabled employees and non-disabled employees, taking account of the full range of jobs and salaries.

By the term 'disability', we mean a health condition (mental or physical) or a neurodivergence which has a substantial and long-term adverse effect on an individual's ability to carry out normal day-to-day activities. For this report, the terms 'disabled' to describe colleagues with disabilities and/or long-term health conditions, and the term 'non-disabled' to describe colleagues who do not have a long-term health condition or a disability, will be used.

The DPG is not about equal pay for work of equal value, which looks at the pay differences between men and women for doing work of equal value, irrespective of disability. Our arrangements for ensuring equal pay for work of equal value are detailed in section 7.

This report is based on 31 March 2026 data.

2. How is the disability pay gap expressed?

Our DPG is reported using six different measures, which are aligned with the gender pay gap reporting framework:

- Mean disability pay gap: The difference between the mean hourly rate of pay of disabled full-pay employees and that of non-disabled full-pay employees
- Median disability pay gap: The difference between the median hourly rate of pay of disabled full-pay employees and that of non-disabled full-pay employees
- Mean bonus gap: The difference between the mean bonus pay paid to disabled employees and that paid to non-disabled employees
- Median bonus gap: The difference between the median bonus pay paid to disabled employees and that paid to non-disabled employees
- Bonus proportions: The proportions of disabled and non-disabled employees who were paid any bonus pay during the relevant period
- Quartile pay bands: The proportions of disabled and non-disabled full-pay employees in the lower, lower middle, upper middle and upper quartile pay bands

A positive pay gap means that, on average, disabled colleagues are paid less overall than non-disabled colleagues. A negative pay gap means the average pay for disabled colleagues is higher than non-disabled colleagues. A pay gap of zero

means that the average pay across the workforce is the same for disabled and non-disabled colleagues.

3. Disability Pay Gap - Average Pay

The figures reported for 2025/26 show West Suffolk NHS Foundation Trust's DPG as mean and median average hourly rates. The mean calculates the total amount earned across the organisation, divided by the number of people employed. The median looks at all the salaries in the range and identifies the mid-point.

Table 1: Average hourly rates by disability grouping summary in 2024-2025 and 2025-2026.

Disability grouping summary	2024-2025		2025-2026	
	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
Yes (disability)	£20.29	£20.36	£22.47	£22.49
No (no disability)	£21.92	£21.31	£23.93	£24.35
Not declared	£22.91	£22.50	£25.21	£25.70
% Difference between staff who have a disability and staff who do not	7.44%	8.75%	6.11%	7.63%

The mean and median average hourly rates for disabled colleagues are £22.47 and £22.49, which is slightly lower than the mean and median average hourly rates for non-disabled colleagues (£23.93 and £24.35, respectively).

Our data shows a mean pay gap of 6.11% between disabled and non-disabled colleagues. This means that for every £1 the average non-disabled person earned, the average disabled person earned £0.94. There is also a median pay gap of 7.63%, which means that for every £1 the median non-disabled person earned, the median disabled person earned £0.92. The mean and median pay gaps between disabled and non-disabled colleagues have reduced since 2024-2025.

Whilst Table 2 intends to show the number of colleagues in each pay quartile by disability, it also highlights that there are large number of colleagues within the Trust whose disability status is recorded as 'not declared' and 'unspecified'.

Table 2: Number of colleagues in each pay quartile by disability in 2025/26 (Q1 low/Q4 high)

Quartile	No	Yes	Prefer not to answer	Not declared	Unspecified ¹
1	842	123	41	53	101
2	932	120	64	63	119
3	913	77	52	68	180
4	799	70	61	77	243
Total	3,486	390	218	261	643

4. Disability disclosure

A reflection upon the data thus far has highlighted the importance of increasing staff EDI disclosure (specifically disability) within our organisation.

Although our EDI workforce monitoring data shows an increase of disability disclosure over the past year, there is still further work to do to increase disclosure and build an informed understanding of the demographic of our workforce.

Below are the percentages of workforce disability declaration data as at 31 March 2026:

Yes: 8% (increase from 7% in 2024-2025)
No: 70% (increase from 68% in 2024-2025)
Prefer not to answer: 5% (same 2024-2025)
Not declared or recorded: 17% (decrease from 20% in 2024-2025)

We know from our annual NHS Staff Survey data that these figures do not fully reflect the true number of staff with a disability or long-term health condition within our organisation.

Increasing our disability disclosure (particularly through the 'yes' and 'no' categories) would significantly strengthen our dataset and enable us to draw strong, robust conclusions.

It is also worth noting a barrier preventing disclosure via ESR. As seen in Image 1 below, there are multiple, conflicting options that colleagues can select within ESR when disclosing their disability information. For example, there is the option to select either 'no' or 'not declared', and there is also an option for colleagues who do have a disability, but it is not reflected in the options included within ESR, to select either 'yes unspecified' or 'other'. Having multiple options that are unclear is not helpful, as it prevents our data from being streamlined and potentially preventing the interpretation of our data accurately.

Image 1: The options available to colleagues to select from when updating their disability information via ESR.

The image shows a screenshot of the ESR (Employee Self-Review) form. It displays three instances of the 'Disability Category' dropdown menu, which are overlapping. The dropdown menu lists the following options: Learning disability/difficulty, Long-standing illness, Mental Health Condition, No, Not Declared, Other, Physical Impairment, Prefer Not to Answer, Sensory Impairment, and Yes - Unspecified. The form also includes fields for 'Start Date'.

5. Work to address to increase disability disclosure

Throughout 2025-2026, our disclosure rates for disability have improved, reflecting growing confidence among colleagues in sharing their information. A key contributor of has been the *Make Your Profile Count* campaign that launched in February 2026. The aim of this campaign was to increase the number of staff who had updated their EDI data through ESR.

As of 31 March 2026, there has been a 6.3% increase in the percentage of our workforce who have updated their disability information using the categories available on ESR. This improvement is a significant step forward in strengthening the accuracy of our workforce data and ensuring that colleagues with disabilities are better represented in our reporting. Specifically, the percentage of staff who identify as disabled has increased to 8%, up from 7% in 2024–2025, the percentage of people who do not identify as having a disability has increased to 70% from 68% in 2024-2025, and the percentage of colleagues who have not declared or recorded their disability status has fallen from 20% to 17%. This reduction in non-disclosure is a positive indicator of improved trust, awareness, and engagement with our data-collection processes.

Although a small proportion of colleagues continue to select “prefer not to answer” (5%), this figure has remained stable over the past year, suggesting that the increase in disclosure is driven by colleagues who were previously unrecorded rather than those who were unwilling to share this information.

6. Disability Pay Gap - Bonus Pay

Bonus pay is any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission.

The following payments are included in the calculation of bonus pay:

- Welcome payments. These are incentives paid in the form of one or two lump sums to staff appointed to areas where recruitment is difficult e.g., pharmacy and staff nurses.
- Recruitment and retention premium. These are on-going increases to base salary for staff appointed to areas where recruitment is difficult e.g., estates trades and craftspeople, pharmacy, clinical coding, sonographers.
- Commitment awards e.g., bonus paid to nursing assistants on completion of their Care Certificate
- Long service awards paid on retirement to staff with over 25 years' service at WSFT

The equal distribution method previously in place for awarding Clinical Excellence Awards (CEAs) is no longer a factor. From 1 April 2024, funding for Local CEAs was redeployed into remuneration.

Table 3: Bonus pay by disability category

Disability category	Mean bonus pay value	Mean average bonus DPG (disability category/No)	Median Avg Bonus value	Median average bonus DPG (disability category/No)	Head count	No. Receiving Bonus	% Receiving Bonus	% of those receiving bonus that are consultants
Learning disability	£6032.04	-30.38%	£6032.04	-100%	91	1	1.10%	100%
Long-standing illness	£3,015.97	34.81%	£3,015.97	0%	84	1	1.19%	100%
Mental health condition	£6,032.04	-30.38%	£6,032.04	-100%	67	1	1.49%	100%
Physical disability	£28409.60	-514.08%	£28,409.60	-841.98%	38	1	2.63%	100%
Sensory impairment	£0	100%	£0	100%	26	0	0%	0%
Other	£0	100%	£0	100%	40	0	0%	0%
Yes-unspecified¹	£17,672.30	-281.99%	£17,672.30	-485.96%	79	1	1.27%	100%
Unspecified	£9,598.05	-107.46%	£6,032.04	-100%	808	21	2.60%	90.48%
No	£4,626.40	-	£3015.96	-	4,094	51	1.25%	70.59%
Prefer not to answer	£0	100%	£0	100%	196	0	0%	0%
Not declared	£3,331.85	27.98%	£3,015.96	0%	320	12	3.75%	75%
Total					5,843	89	1.52%	77.53%

7. Reflections:

As highlighted throughout this report, there are two significant barriers within this area of work:

1. High 'non-disclosure' rates. This means that a large percentage of our colleagues have not shared or updated their EDI information (specifically, in this case, their information regarding any disabilities or long-term health conditions they may or may not have) with the organisation through ESR. Although there have been improvements over the last year, there is further work to be done.
2. The options on ESR are conflicting, and having multiple options is a barrier preventing the streamlining and accurate interpretation of our data. ESR is a national workforce system and amendments to address this barrier cannot be implemented locally.

8. What are we doing to decrease the disability pay gap within our Trust?

Our pay gap action plan (appendix A) contains the actions that have been embedded into our Trust's EDI priority plan to continue work to address our DPG. These actions are a part of our wider work and commitment to address the disparity in experiences and outcomes between our disabled and non-disabled colleagues.

We acknowledge that meaningful progress requires sustained, intentional effort, and the impact of the work we are undertaking to close the DPG and advance equity across the demographic of our organisation will take time to embed and evidence. Therefore, some actions identity last year remains in place. Where this is the case, an update has been provided on the progress made since 2024-2025.

9. How we ensure equal pay for work of equal value

West Suffolk NHS Foundation Trust delivers equal pay through adopting nationally agreed terms and conditions for our workforce. These are the National NHS Agenda for Change Terms and Conditions of Service (AfC).

AfC is negotiated nationally by the NHS Staff Council, led by NHS Employers. The national NHS Staff Council has overall responsibility for the AfC pay system and has representatives from both employers and trade unions. AfC provides the framework for pay arrangements which are in place at West Suffolk NHSFT. Typically, AfC terms and conditions apply to nursing, allied health professionals and administration, management, and clerical staff, which are most of the workforce.

Medical staff are employed on national terms and conditions of service and pay arrangements. These pay arrangements are negotiated nationally on behalf of employers by NHS Employers with the NHS trade unions. These terms and conditions include all Consultants, Medical and Dental staff and Doctors and Dentists in Training.

Open Board

Report information

Report title: Ethnicity pay gap report 2025-2026

Agenda item: -

Sponsor/Executive lead: Sarah Hodds, Interim chief people officer

Report prepared by: Jamais Webbsmall-Eghan, Head of inclusion

Previously considered by: Workforce wellbeing and inclusion group (June 2026), People, culture and organisational development committee (August 2026)

This report is for: ☒ Approval ☒ Assurance ☐ Discussion ☐ Information

This report supports the following ambitions within the organisational strategy:

- ☐ High quality care ☐ Joined up services
- ☒ Empowered to improve ☐ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

Our data shows that we have a mean ethnicity pay gap (EPG) of -15.81 and a median EPG of -9.75. Both the mean and median EPG have widened since last year, where they were -13.78 and -8.81, respectively. This negative pay gap means that, for every £1 the average Global Majority person earned, the average White person earned £0.86. It also means that for every £1 the median Global Majority person earned, the median White person earned £0.91. This is the case because there are proportionally more Global Majority colleagues than White colleagues in more senior, higher paying jobs in comparison to the overall workforce demographic.

However, we must acknowledge that this data is weighted by specific staff groupings (medical consultants) rather than being reflective of the wider workforce profile, as this is a trend that is not seen as strongly within the Agenda for Change pay bands. When medical consultant data are removed from analysis, the mean EPG is -6.63 and the median EPG is -9.19. This means that for every £1 the average (non-consultant) Global Majority person earned, the average (non-consultant) White person earned £0.94. It also means that for every £1 the median (non-consultant) Global Majority person earned, the median (non-consultant) White person earned £0.91.

Whilst this is still a negative pay gap, there is a difference in the figures. This highlights the importance of analysing our ethnicity pay gap both with and without medical consultant data to ensure we are presenting a picture that accurately reflects the wider workforce.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

Reviewing this data in conjunction with the EDI monitoring data again highlights the demographic of colleagues within the Trust, placing a spotlight on the over representation of Global Majority colleagues within band 5, and the underrepresentation of Global Majority colleagues in bands 7 and above. Additionally, the Trust's recruitment data consistently shows disparity between White applicants and Global Majority applicants (particularly Black candidates) within our recruitment and selection processes.

Therefore, our data suggests that we need to adopt a holistic approach to increasing representation of Global Majority colleagues within our organisation. It is not just about increasing representation at senior levels but unblocking the band 5 pipeline to enable Global Majority colleagues to progress.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*

Actions have been identified to address the ethnicity pay gap within our organisation. This forms a part of our wider anti-racism work and commitment to address race inequity within our Trust.

Action required by the Group:

- Review the data presented within the report. Ensure that it has been analysed fully and the narrative within this report is informative, clear, and accessible for all.
- Note the actions within the pay gap action plan. The pay gap action plan contains actions to address the gender, ethnicity and disability pay gaps within the Trust. Many of these are existing actions or actions that have evolved as the result of ongoing work.
- Approve the report and the pay gap action plan for internal and external publication

Governance and compliance

Risk and assurance:

This is the second year that the Trust has produced its EPG report. Reporting on the EPG is a requirement of High Impact Action 3 within the NHS EDI Improvement Plan, which focuses on identifying pay gaps and implementing improvement plans to eliminate them.

Equality, diversity and inclusion:

Taking action to understand and address our EPG is one of the areas we are unequivocally committed to as we continue our work to be an anti-racist Trust.

Sustainability:

Addressing ethnicity pay disparities supports the Trust's long-term commitment to race equity and anti-racism. The work arising from this report seeks to address the systemic, structural and cultural factors that can contribute to inequitable outcomes in recruitment, progression, development and reward. By embedding anti-racist principles within our organisational culture, leadership and workforce practices, the Trust aims to create sustainable and lasting change that improves the experiences and opportunities available to Global Majority colleagues. This contributes to a more representative, inclusive and equitable organisation, strengthening workforce sustainability and supporting the Trust's ambition to become and remain an anti-racist organisation.

Legal and regulatory context:

As an employer with more than 250 employees, WSFT is required to report its Gender Pay Gap data every year by 31 March.

At this current time, reporting on the EPG is not a statutory requirement. This will change in due course (the exact timeline is currently unclear) as the Government has committed to introducing mandatory ethnicity and disability pay gap reporting for organisations with more than 250 employees.

Ethnicity pay gap report 2026

1. What is the ethnicity pay gap?

The ethnicity pay gap (EPG) looks at the difference in the average hourly pay between Global Majority staff and White staff, taking account of the full range of jobs and salaries.

The EPG is not about equal pay for work of equal value, which looks at the pay differences between men and women of all ethnicities for doing work of equal value. Our arrangements for ensuring equal pay for work of equal value are detailed in section 6.

This report is based on 31 March 2026 data.

2. How is the ethnicity pay gap expressed?

A positive pay gap means that, on average, Global Majority colleagues are paid less overall than White colleagues. A negative pay gap means the average pay for Global Majority colleagues is higher than White colleagues. A pay gap of zero means that the average pay across the workforce is the same for Global Majority colleagues and White colleagues.

The EPG is reported using six different measures:

- Mean ethnicity pay gap: The difference between the mean hourly rate of pay of Global Majority full-pay employees and that of White full-pay employees.
- Median ethnicity pay gap: The difference between the median hourly rate of pay of Global Majority full-pay employees and that of White full-pay employees.
- Mean bonus gap: The difference between the mean bonus pay paid to Global Majority employees and that paid to White employees.
- Median bonus gap: The difference between the median bonus pay paid to Global Majority employees and that paid to White employees.
- Bonus proportions: The proportions of Global Majority and White employees who were paid any bonus pay during the relevant period.
- Quartile pay bands: The proportions of Global Majority and White full-pay employees in the lower, lower middle, upper middle and upper quartile pay bands.

3. Ethnicity pay gap - average pay

The figures reported below show West Suffolk NHS Foundation Trust's EPG as both mean and median hourly rates. The mean calculates the total amount earned across the organisation, divided by the number of people employed. The median looks at all the salaries in the range and identifies the mid-point.

Table 1: Average hourly rates by ethnic origin grouping summary in 2023-24, 2024-25 and 2025-26.

	2023-2024		2024-2025		2025-2026	
Ethnic origin grouping summary	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
White ¹	£20.29	£17.68	£21.88	£18.66	£22.74	£19.71
Global Majority ²	£22.79	£18.74	£24.89	£20.30	£26.34	£21.63
Not known ³	£20.83	£18.37	£23.19	£20.20	£23.91	£21.31
% Difference between White and Global Majority	-12.33%	-5.99%	-13.78%	-8.81%	-15.81%	-9.75%
% Difference between White and Not known	-2.68%	-3.89%	-6.00%	-8.28%	-5.12%	-8.10%

¹ = White British, White Other stated

² = Asian, Black, Mixed

³ = Null, not stated

Our data shows a negative mean and median pay gap between White colleagues and Global Majority colleagues (-15.81% and -9.75%, respectively). This means that the average pay for Global Majority colleagues is higher than the average pay for White colleagues. The negative mean and median pay gap between White colleagues and Global Majority colleagues has widened over the last two years.

The reason the difference between White and Not Known has been included is because the number of colleagues who have not disclosed their ethnicity data through ESR is significant (see Table 3).

The term 'Global Majority' is an umbrella term that refers to ethnicities that are not White. Whilst, for this report, the above data informs us that there is a negative ethnicity pay gap, it cannot tell us where this gap might specifically appear within the ethnicities included in the Global Majority grouping. Therefore, this data has been disaggregated further by the different ethnic groups within the Global Majority category to identify specifically where larger or smaller ethnicity pay gaps might lie. This data can be observed in Table 2.

Table 2: Average hourly rates by ethnic origin groups in 2023-24, 2024-25 and 2025-26

	2023-2024		2024-2025		2025-2026	
Ethnic origin grouping	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
White British	£20.12	£17.69	£21.55	£18.66	£22.61	£19.73
Asian	£22.76	£18.69	£25.05	£20.15	£26.56	£21.56
Black	£21.58	£18.40	£23.47	£20.58	£25.22	£22.39
Mixed	£22.70	£19.10	£24.20	£20.14	£24.12	£19.98
Other	£25.44	£20.74	£27.12	£22.88	£28.81	£24.79
White Other	£21.78	£17.32	£24.77	£18.49	£23.82	£19.46
Not Stated	£21.11	£19.18	£23.52	£20.81	£25.51	£23.82
NULL	£20.70	£17.69	£23.04	£20.14	£23.42	£20.57
% difference White British and Asian	-13.15%	-5.70%	-16.25%	-8.00%	-17.47%	-9.27%
% difference White British and Black	-7.30%	-4.03%	-8.92%	-10.29%	-11.54%	-13.44%
% difference White British and Mixed	-12.84%	-8.01%	-12.29%	-7.94%	-6.67%	-1.25%
% difference White British and Other	-26.84%	-17.27%	-25.87%	-22.60%	-27.41%	-25.63%
% difference White British and White Other	-8.27%	2.09%	-14.96%	0.92%	-5.36%	1.39%
% difference White British and Not Stated ¹	-4.94%	-8.46%	-9.14%	-11.54%	-12.79%	-20.71%
% difference White British and Null ²	-2.89%	0.00%	-6.95%	-7.94%	-3.56%	-4.25%

¹ Not Stated= colleagues who have selected 'prefer not to say'

² Null= colleagues who have not shared or updated their ethnicity data via ESR.

Data shows that the negative mean and median pay gaps between White British and Other are the largest, followed by White British and Asian, White British and Not Stated and White British and Black. All of these pay gaps have widened over the past year.

Conversely, the pay mean and median gaps between White British and Mixed and White British and Null have decreased and the figures are the closest to zero, which represents equity.

The mean pay gap between White British and White Other has decreased significantly from 2024-25, and there has been a slight increase in the median pay gap, which is a positive pay gap. This means that the average pay for White British colleagues is higher than the average pay for colleagues who identify with other White ethnicities.

An observation to make here is the importance of continuing to increase the number of staff who share and update their EDI information via ESR. Whilst 94% of colleague have shared an updated their ethnicity through ESR, if colleagues who had not yet disclosed their ethnicity information (currently recorded as 'Null') did this so and if their data was incorporated into an ethnic origin group, it has the potential to change the landscape of the picture this data is presenting, which could result in a pay gap yet not seen. This is illustrated by data in Table 3 that shows there are more colleagues within the Trust whose ethnicity is recorded as 'Null' than we have colleagues who have shared their ethnicity as Black, Mixed-Race or Other.

Table 3: Number of colleagues in each pay quartile by ethnicity in 2025/26 (Q1 low/Q4 high)

Quartile	White British	Asian	Black	Mixed	Other	White Other	Not Stated	Null
1	876	73	25	23	13	101	9	43
2	946	219	41	16	16	133	17	80
3	775	273	58	22	20	78	20	69
4	853	181	48	15	29	105	30	55
Total	3,450	746	172	76	78	417	76	247

From the data thus far, it can be determined that average hourly rate of pay for Global Majority colleagues is higher than that of White British colleagues. When looking at the demographic of our workforce, it may be surprising that this is the case as there is a larger percentage of White British colleagues than Global Majority colleagues and colleagues from other White backgrounds. However, we must recognise that the EPG at WSFT is caused by the fact there are proportionally more Global Majority colleagues than White colleagues in more senior, higher paying jobs in comparison to the overall workforce demographic. Whilst this is positive profile, it should be noted that this data reflects specific staff groupings rather than the wider workforce profile.

Table 3 highlights that there are more Asian and Black colleagues, colleagues with a Mixed ethnic background, and colleagues identifying as 'Other' in Q3 and Q4 (the

highest pay quartiles) than in Q1 and Q2. This is the opposite for White British and White Other colleagues.

Through reviewing this data, it is suggested that the data is heavily weighted by the consultant staff group. This is because representation of Global Majority colleagues at this level is not representative of the wider workforce. For example, the proportion of Global Majority consultants (37.58%) is higher than the proportion of Global Majority colleagues across the Trust more widely (20.64%). Additionally, as another example, data in Table 5 shows that 24.16% of our consultants are Asian, whereas our 2025-26 EDI monitoring data shows that Asian colleagues make up 12.21% of our overall workforce. Incorporating consultant data within this report is heavily weighting our findings and potentially masking the averages that are reflective of wider staff groups.

Table 4: proportion of medical consultants in post at 31 March 2026 by ethnic origin grouping summary:

White		Global Majority		Not Stated	
Headcount		Headcount		Headcount	
No.	%	No.	%	No.	%
165	55.37	112	37.58	21	7.05%

Table 5: proportion of medical consultants in post at 31 March 2026 by ethnic origin grouping detail:

White		Asian		Black		Mixed		Other		Not Stated	
Headcount		Headcount		Headcount		Headcount		Headcount		Headcount	
No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
165	55.37	72	24.16	14	4.70	8	2.68	18	6.04	21	7.05

To better understand our workforce data, we have committed to running our EPG both with and without consultant data included.

Table 6: Average hourly rates by ethnic origin grouping summary in 2023-24, 2024-25 and 2025-26 (excluding medical consultants)

	2023-2024		2024-2025		2025-2026	
Ethnic origin grouping summary	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
White ¹	£18.57	£16.90	£20.32	£18.62	£21.07	£19.33
Global Majority ²	£18.13	£17.74	£21.24	£19.76	£22.46	£21.11
Not stated ³	£18.84	£17.68	£21.93	£20.00	£22.45	£21.02
% Difference between White and Global Majority	2.37	-4.95	-4.51	-6.13	-6.63	-9.19
% Difference between White and Not known	-1.48	-4.65	-7.91	-7.39	-6.56	-8.74

¹ = White British, White Other
stated

² = Asian, Black, mixed

³ = NULL, not

Table 7: 2025-2026 average hourly rates by ethnic origin group summary (including and excluding medical consultants)

	<u>Including</u> consultant data		<u>Excluding</u> consultant data	
	2025-2026		2025-2026	
Ethnic origin grouping summary	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
White ¹	£22.74	£19.71	£21.07	£19.33
Global Majority ²	£26.34	£21.63	£22.46	£21.11
Not stated ³	£23.91	£21.31	£22.45	£21.02
% Difference between White and Global Majority	-15.81%	-9.75%	-6.63	-9.19
% Difference between White and Not known	-5.12%	-8.10%	-6.56	-8.74

¹ = White British, White Other
stated

² = Asian, Black, mixed

³ = NULL, not

As seen in Tables 6 and 7, excluding medical consultants from this data has an impact upon the mean hourly rate of White and Global Majority colleagues, and the percentage difference between White and Global Majority colleagues. For White colleagues, the mean hourly rate with medical consultants included is £22.74 and it

is £21.07 without this staff group. For Global Majority colleagues, the mean hourly rate with medical consultants included is £26.34 and it is £22.46 without this staff group. It should therefore be noted that, upon the removal of the medical consultant data, the mean hourly rates decrease more for Global Majority colleagues than for White colleagues. Regarding the median hourly rate, there were slight decreases for both White and Global Majority colleagues when consultant data was removed.

The mean percentage difference between White and Global Majority colleagues is -15.81% with the medical consultant staff group included, and it reduces to -6.63 once this data set is excluded. This highlights that there remains a pay gap where the average pay is higher for Global Majority colleagues than for White colleagues, but it is not as high once the data from medical consultants are removed. This suggests that analysing this data in this way (i.e. running reports both with and without medical consultant data) is helpful in providing a more accurate reflection of the EPG within our organisation.

In addition to this, the data in Table 8 (which has been disaggregated further by the different ethnic groups within the Global Majority category to identify specifically where larger or smaller ethnicity pay gaps might lie) highlights several differences in the direction of pay gaps when medical consultant data is removed.

Table 8: 2025-2026 average hourly rates by ethnic origin group (including and excluding medical consultants)

Ethnic origin grouping	<u>Including</u> consultant data		<u>Excluding</u> consultant data	
	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
White British	£22.61	£19.73	£21.06	£19.33
Asian	£26.56	£21.56	£22.36	£21.10
Black	£25.22	£22.39	£22.96	£21.86
Mixed	£24.12	£19.98	£20.36	£19.30
Other	£28.81	£24.79	£24.40	£22.80
White Other	£23.82	£19.46	£21.12	£18.92
Not Stated	£25.51	£23.82	£24.09	£23.82
NULL	£23.42	£20.57	£21.94	£19.93
% difference White British and Asian	-17.47%	-9.27%	-6.19%	-9.15%
% difference White British and Black	-11.54%	-13.44%	-9.03%	-13.09%
% difference White British and Mixed	-6.67%	-1.25%	3.33%	0.14%
% difference White British and Other	-27.41%	-25.63%	-15.88%	-17.95%
% difference White British and White Other	-5.36%	1.39%	-0.27%	2.11%
% difference White British and Not Stated ¹	-12.79%	-20.71%	-14.39%	-23.24%
% difference White British and Null ²	-3.56%	-4.25%	-4.20%	-3.12%

¹ Not Stated= colleagues who have selected 'prefer not to say' ² Null= colleagues who have not shared or updated their ethnicity data via ESR.

The mean and median percentage differences between White British and Mixed have decreased and changed from negative figures to positive figures when the consultant data is excluded, highlighting that there is now a positive pay gap between White British colleagues and colleagues from a Mixed ethnic background. Additionally, the mean percentage differences between White British and: Asian, Black, Other, and White Other have decreased when the consultant data is excluded. Although these remain as negative figures, they are closer to zero (which indicates equity).

4. Ethnicity pay gap- bonus pay

Bonus pay is any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission.

The following payments are included in the calculation of bonus pay:

- Welcome payments. These are incentives paid in the form of one or two lump sums to staff appointed to areas where recruitment is difficult e.g., pharmacy and staff nurses.
- Recruitment and retention premium. These are on-going increases to base salary for staff appointed to areas where recruitment is difficult e.g., estates trades and craftspeople, pharmacy, clinical coding, sonographers.
- Commitment awards e.g., bonus paid to nursing assistants on completion of their Care Certificate
- Long service awards paid on retirement to staff with over 25 years' service at WSFT

The equal distribution method previously in place for awarding Clinical Excellence Awards (CEAs) is no longer a factor. From 1 April 2024, funding for Local CEAs was redeployed into remuneration.

Table 9: 2025-2026 Bonus pay gap by ethnic group (summary)

Ethnic Group (summary)	Avg bonus pay value	Mean Avg Bonus EPG	Median bonus pay value	Median Avg Bonus EPG	Head count	No. Receiving Bonus	% Receiving Bonus	% of those receiving bonus that are consultants
White	6515.15	0%	3015.96	0%	4,234	57	1.35%	70.18%
Asian	4806.85	26.22%	0	100%	700	22	3.14%	95.45%
Black	0	100%	0	100%	202	0	0	0%
Mixed	4377.72	32.81%	4377.72	-45.15%	86	2	2.33%	100%
Other	4965.57	23.78%	2865.24	5%	226	5	2.21	80%
Not Stated	6936.96	-6.47%	2262.00	25%	395	3	0.76%	66.67%
Total					5,843	89	1.52%	77.53%

Table 10: 2025-2026 Clinical excellence awards (CEA) totals by ethnic group

Ethnic Group	Consultants with CEA Lv1-9	% makeup of Consultants with CEA	Total consultants	% of Consultant Headcount
White	40	57.97%	165	55.37%
Asian	21	30.43%	72	24.16%
Black	0	0%	14	4.70%
Mixed	2	2.90%	8	2.68%
Other	4	5.80%	18	6.04%
Not Stated	2	2.90%	21	7.05%
Total	73	100%	300	100%

The replacement of the previous equal distribution method for awarding CEAs, combined with the continuation of discretionary awards, and the legacy of previous awarding schemes has contributed to persistent disparities and resulted in CEA awards that are unevenly distributed across ethnic groups (Table 10). This consultant level data shows that White consultants hold 57.97% of all CEAs, which is broadly proportionate and in line with the demographic of the wider consultant workforce (55.37%). Asian consultants hold 30.43% of CEAs, a proportion that exceeds their overall representation within the consultant workforce (24.16%), indicating a higher relative uptake of CEA awards among this group. In contrast, Black consultants hold no CEAs, despite representing nearly 4.70% of the consultant workforce. Mixed and Other groups hold small numbers of CEAs, broadly proportionate to their respective consultant headcount.

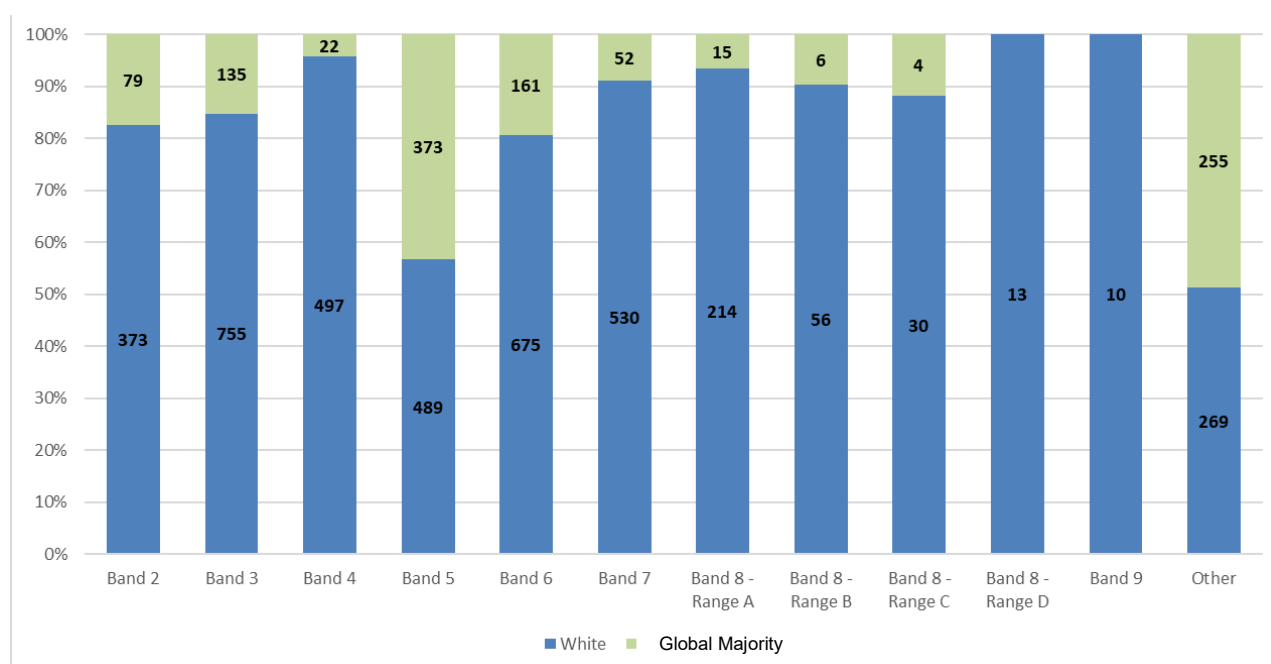
Taken together, the data in Tables 9 and 10 indicate that legacy discretionary awards continue to reinforce inequitable and unequal outcomes, with the absence of CEA awards for Black consultants being an example of this.

5. Reflections

Whilst data in this report shows that WSFT has an ethnicity pay gap that advantages Global Majority colleagues, we should note that it is not necessarily a reflection of progression within our organisation.

Graph 1 is sourced from the Trust's 2026 EDI monitoring data, and it illustrates the representation of White and Global Majority colleagues within Agenda for Change (AfC).

Graph 1: The number of Global Majority and White colleagues by AfC pay bands as at 31 March 2026



Although colleagues from the Global Majority make up 20.64% of our overall workforce, this is not reflected consistently throughout the AFC bands within our Trust. As shown in Graph 1, Global Majority colleagues are highly represented at band 5 (43.27%) but this sharply decreases at band 6 (19.26%), which is line with the wider Trust demographics. The representation of Global Majority colleagues rapidly decreases as the bands increase. By bands 8D and 9, there is no representation of Global Majority colleagues, highlighting a clear absence of ethnic diversity with our most senior, non-medical positions. This does not reflect the findings for medical consultants where the representation of Global Majority colleagues is significantly higher.

Table 11 shows the proportion of White and Global Majority colleagues across each band, highlighting that band 4 and bands 7 and above have the lowest Global

Majority representation when compared with the demographic and ethnic profile of the wider organisation

Table 10: Representation of White and Global Majority colleagues by AfC band

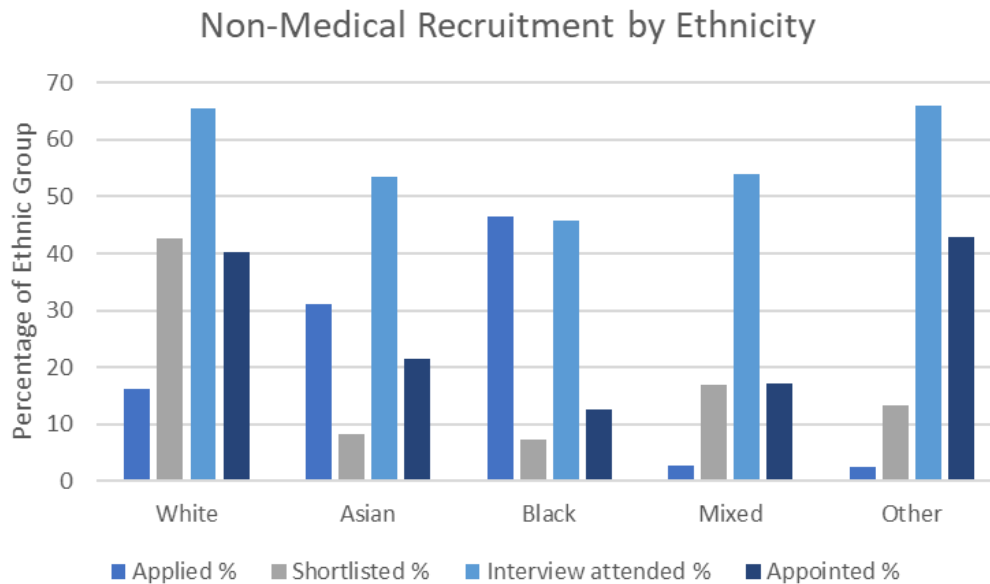
Band	% of White colleagues	% of Global Majority
2	82.52%	17.48%
3	84.83%	15.17%
4	95.76%	4.24%
5	56.73%	43.27%
6	80.74%	19.26%
7	91.07%	8.93%
8a	93.45%	6.55%
8b	90.32%	9.68%
8c	88.24%	11.76%
8d	100%	0%
9	100%	0%

In addition to this, the Trust's recruitment data shows disparity between White applicants and Global Majority applicants at the points of shortlisting and appointment.

Graph 2 highlights that, across all four stages of the recruitment and selection process (applied, shortlisted, interview attended and appointed), the proportion of White applicants remains relatively steady. This indicates that the number of White candidates progressing through each stage of the process is broadly aligned with the number of initial applications.

On the other hand, Graph 2 shows a decline in representation at each successive stage in the process for candidates from Asian, Black and Mixed ethnic groups. Specifically, Black applicants show a significant reduction from application to appointment in comparison to other ethnic groups, suggesting that Black candidates face the greatest barriers when progressing through our recruitment and selection processes.

Graph 2: Non-Medical Recruitment by Ethnicity (Rolling 12 Months to April 2026)



6. What are we doing to close the ethnicity pay gap within our Trust?

Our pay gap action plan (appendix A) contains the actions that have been embedded into our Trust's EDI priority plan to continue work to address our EPG. These actions are a part of our wider work and commitment to address and improve race equity within our Trust.

We acknowledge that meaningful progress requires sustained, intentional effort, and the impact of the work we are undertaking to close the EPG and advance racial equity across the demographic of our organisation will take time to embed and evidence.

7. How we ensure equal pay for work of equal value

West Suffolk NHS Foundation Trust delivers equal pay through adopting nationally agreed terms and conditions for our workforce. These are the National NHS Agenda for Change Terms and Conditions of Service (AfC).

AfC is negotiated nationally by the NHS Staff Council, led by NHS Employers. The national NHS Staff Council has overall responsibility for the AfC pay system and has representatives from both employers and trade unions. AfC provides the framework for pay arrangements which are in place at West Suffolk NHSFT. Typically, AfC terms and conditions apply to nursing, allied health professionals and administration, management, and clerical staff, which are most of the workforce.

Medical staff are employed on national terms and conditions of service and pay arrangements. These pay arrangements are negotiated nationally on behalf of employers by NHS Employers with the NHS trade unions. These terms and conditions include all Consultants, Medical and Dental staff and Doctors and Dentists in Training.

Open Board

Report information

Report title: Gender pay gap report 2025-2026

Agenda item: -

Sponsor/Executive lead: Sarah Hodds, Interim chief people officer

Report prepared by: Jamais Webbsmall-Eghan, Head of inclusion

Previously considered by: Workforce wellbeing and inclusion group (June 2026), People, culture and organisational development group (August 2026)

This report is for: ☒ Approval ☒ Assurance ☐ Discussion ☐ information

This report supports the following ambitions within the organisational strategy:

- ☐ High quality care ☐ Joined up services
- ☒ Empowered to improve ☐ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

Our data shows that we have a mean gender pay gap (GPG) of 20.36%, which is a decrease from 21.95% in 2025. This means that for every £1 the average man earned, the average woman earned £0.80. We also have a median GPG of 9.20%, which is an increase from 7.56% in 2025. This means that for every £1 that the median man earned, the median woman earned £0.91

This paper explores our data, before outlining the ongoing areas of work that are in place to continue closing the GPG that exists within the Trust.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

All employers with 250 or more employees are required by law to publish their GPG each year on their own and the Government's website. The Trust must publish data for the year ending 31 March 2026 by 31 March 2027.

In addition to this, the Employment Rights Act 2025 introduced a new requirement from employers with more than 250 employees to produce menopause action plans detailing how they will support employees experiencing menopause. These action plans should link with broader gender equality initiatives, such as gender pay gap reporting.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*

A discussion should take place to ensure that our GPG has been analysed fully and the narrative within this report is informative, clear, and accessible for all. Once approved, the report should be uploaded to the Trust's website and submitted to the Government's gender pay gap portal by the end of March 2027 to ensure that we uphold our legal requirements and enable transparency of this data for our colleagues, patients and the public.

As a Trust, we have opted to voluntarily include and publish the actions we have implemented to support colleagues experiencing menopause ahead of Spring 2027, where this requirement is expected to become mandatory. These actions are contained and monitored within the Trust's Health and Wellbeing plan.

Our pay gap action plan (containing all actions to address our gender, ethnicity and disability pay gaps and includes actions in place to support colleagues experiencing the menopause) can be found in Appendix A. Appendix B provides a detailed update on the Trust's menopause action plan.

Action required by the Group:

- Review the data presented within the report. Ensure that it has been analysed fully and the narrative within this report is informative, clear, and accessible for all.
- Note the actions within the pay gap action plan
- Approve the report and the pay gap action plan for internal and external publication

Governance and compliance

Risk and assurance: The Trust's Gender Pay Gap data will be uploaded to the Government website and submitted ahead of the 30 March 2027 deadline.

Equality, diversity and inclusion:

Taking action to close our gender pay gap and supporting colleagues experiencing menopause are two of the areas of work we are committed to as we work towards embedding gender equity within our Trust.

Sustainability:

Understanding and addressing gender pay disparities is an important component of creating a fair, inclusive and sustainable workplace. The work outlined within this report supports the Trust's commitment to equality of opportunity by identifying and addressing barriers that may affect career development, progression and representation. Through sustained focus on equity and inclusion, the Trust can

create lasting cultural and organisational change that supports long-term workforce and organisational sustainability.

Legal and regulatory context:

As an employer with more than 250 employees, WSFT is required to report its GPG data every year by 30 March. Although not yet mandatory, the Trust has included actions to support colleagues experiencing menopause within our pay gap action plan. This requirement is expected to become mandatory in Spring 2027.

Gender pay gap report 2026

1. What is the gender pay gap?

All employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website. The Trust must publish data for the year ending 31 March 2026 by 30 March 2027.

The gender pay gap (GPG) looks at the difference in the average pay between all men and women in an organisation, taking account of the full range of jobs and salaries. The gender pay gap is not about equal pay for work of equal value (i.e. paying men and women the same for doing the same or broadly similar jobs or for work of equal value). Our arrangements for ensuring equal pay for work of equal value are detailed in section 6.

This report is based on 31 March 2026 data.

2. How is the gender pay gap expressed?

A positive pay gap means that, on average, women earn less than men. A negative pay gap means the average pay for women is higher than for men. A pay gap of zero means that the average pay across the workforce is the same for both men and women.

The GPG is reported using six different measures:

- **Mean:** The difference between the mean hourly rate of pay of male full-pay employees and that of female full-pay employees
- **Median:** The difference between the median hourly rate of pay of male full-pay employees and that of female full-pay employees
- **Mean bonus:** The difference between the mean bonus pay paid to male employees and that paid to female employees
- **Median bonus:** The difference between the median bonus pay paid to male employees and that paid to female employees
- **Bonus proportions:** The proportions of male and female relevant employees who were paid any bonus pay during the relevant period
- **Quartile pay bands:** The proportions of male and female full-pay employees in the lower, lower middle, upper middle and upper quartile pay bands

3. Gender pay gap - average pay

The figures reported below show West Suffolk NHS Foundation Trust's GPG as both mean and median hourly rates. The mean calculates the total amount earned across the organisation, divided by the number of people employed. The median looks at all the salaries in the range and identifies the mid-point.

Our 2025/26 data show the mean and median hourly rate of pay for women (£22.30 and £19.98, respectively) remained lower than the mean and median hourly rate of men (£28.00 and £22.00, respectively), resulting in a mean pay gap of 20.36% and a median pay gap of 9.20%. This can be seen in table 1:

Table 1: Mean and median hourly rate of pay (and the percentage difference in this pay) by gender as at 31 March 2026

Gender	Mean hourly rate	Median hourly rate
Male	£28.00	£22.00
Female	£22.30	£19.98
Difference	£5.70	£2.02
Pay gap %	20.36%	9.20%

Table 2 highlights that, over the past year, there has been a 1.59% decrease in the mean GPG (from 21.95% to 20.36%), which is very close to the and an increase of 1.64% in the median GPG (from 7.56% to 9.20%). The mean and median GPGs between 2021 and 2026 can be seen in Table 2 below.

Table 2: Annual mean and median gender pay gap from 2021 to 2026.

Year	Mean % pay gap	Median % pay gap
31.03.21	22.30%	7.10%
31.03.22	22.35%	8.00%
31.03.23	20.80%	7.41%
31.03.24	20.33%	9.46%
31.03.25	21.95%	7.56%
31.03.26	20.36%	9.20%

4. What causes this gap?

When looking at the demographic of our workforce by gender, it may be surprising that the GPG is large as there is a larger percentage of women within our workforce than men (women = 78%, men = 22%). However, we must recognise that there is a GPG at WSFT because there are proportionally more men than women in senior, higher paying jobs in comparison to the overall workforce demographic. This means that the pay gap between men and women will not be narrowed until there are proportionately more women employed in high salaried roles.

The decrease in the mean GPG and the increase in the median GPG over the last year can be explained by looking at the headcount of all staff by gender and the proportion of men and women working for the Trust by pay quartile.

Table 3: Headcount total of all staff by gender in 2024/25:

Gender	Headcount	%
Female	4,292	78.8
Male	1157	21.2
Grand total	5449	100.0

Table 4: Headcount total of all staff by gender in 2025/26:

Gender	Headcount	%
Female	4106	78
Male	1156	22
Grand total	5262	100.0

Table 5: Distribution of men and women across pay quartiles in 2024/25 (Q1 low/Q4 high):

Quartile	Female	Male	Female %	Male %
1	1092	239	82.04	17.96
2	1120	273	80.40	19.60
3	1134	228	83.26	16.74
4	946	417	69.41	30.59

Table 6: Distribution of men and women across pay quartiles in 2025/26 (Q1 low/Q4 high):

Quartile	Female	Male	Female %	Male %
1	939	224	80.74%	19.26%
2	1186	282	80.79%	19.21%
3	1082	233	82.28%	17.72%
4	899	417	68.31%	31.69%

The first thing to note from our 2025/26 headcount data (Table 4) is that the proportion of women across the Trust has decreased by 0.8% since 2024/25 (Table 3).

When reviewing the distribution of men and women by pay quartiles, there has also been a decrease in the number of women in quartiles 3 and 4 since 2024/25. The combination of a lower overall female headcount and a reduced percentage of women within the highest paying quartiles has decreased the representation of

women in senior, higher paying roles. This has contributed towards the decrease in the mean GPG and the increase in the median GPG since 2024/2025.

5. Gender pay gap- bonus pay

Bonus pay is any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission.

The main payment that would currently fit the description of bonus, per gender pay gap reporting, is the Clinical Excellence Award (now replaced with the National Clinical Impact Award Scheme) which are given to senior doctors (Consultants).

The following payments are included in the calculation of bonus pay:

- Welcome payments. These are incentives paid in the form of one or two lump sums to staff appointed to areas where recruitment is difficult e.g., pharmacy and staff nurses.
- Recruitment and retention premium. These are on-going increases to base salary for staff appointed to areas where recruitment is difficult e.g., estates trades and craftspeople, pharmacy, clinical coding, sonographers.
- Commitment awards e.g., bonus paid to nursing assistants on completion of their Care Certificate
- Long service awards paid on retirement to staff with over 25 years' service at WSFT

Table 7: Average bonus pay by gender from 2022 to 2026

Bonus pay	2022		2023		2024		2025		2026	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
% staff receiving bonus pay	5.36%	7.61%	1.94%	4.71%	1.40%	3.98%	1.67%	3.54%	0.94%	3.58%
Mean average bonus pay	£1,741	£5,310	£3,939	£7,270	£4,111	£7,260	£3,425	£7,322	£5,482	£6,421
Mean average bonus GPG	67.21%		45.82%		43.38%		53.22%		14.62%	
Median average bonus pays	£300	£3,016	£1,828	£6,032	£2,500	£5,890	£1,925	£4,970	£2,995	£4,533
Median average bonus GPG	90%		70%		58%		61%		34%	

Table 7 shows that the 2025-2026 mean bonus GPG is 14.62% and the median bonus GPG is 34%. Both averages have significantly decreased since last year and are the lowest they have been in the five-year reporting period.

6. What are we doing to close the gender pay gap within our Trust?

Our pay gap action plan (appendix A) contains the actions that have been embedded into our Trust's EDI priority plan to continue work to address our GPG. These actions are a part of our wider work and commitment to enhance gender equality within our Trust. In addition to this, our action plan also contains actions that we are taking to support employees experiencing menopause.

We acknowledge that meaningful progress requires sustained, intentional effort, and the impact of the work we are undertaking to close the GPG will take time to embed and evidence. Therefore, some actions identified last year remain in place. Where this is the case, an update has been provided on the progress made since 2024-2025.

7. How we ensure equal pay for work of equal value

West Suffolk NHS Foundation Trust delivers equal pay through adopting nationally agreed terms and conditions for our workforce. These are the National NHS Agenda for Change Terms and Conditions of Service (AfC).

AfC is negotiated nationally by the NHS Staff Council, led by NHS Employers. The national NHS Staff Council has overall responsibility for the AfC pay system and has representatives from both employers and trade unions. AfC provides the framework for pay arrangements which are in place at West Suffolk NHSFT. Typically, AfC terms and conditions apply to nursing, allied health professionals and administration, management, and clerical staff, which are most of the workforce.

Medical staff are employed on national terms and conditions of service and pay arrangements. These pay arrangements are negotiated nationally on behalf of employers by NHS Employers with the NHS trade unions. These terms and conditions include all Consultants, Medical and Dental staff and Doctors and Dentists in Training.

Open Board

Report information

Report title: Workplace Disability Equality Standard (WDES) report 2026

Agenda item: -

Sponsor/Executive lead: Sarah Hodds, Interim chief people officer

Report prepared by: Jamais Webbsmall-Eghan, Head of inclusion

Previously considered by: People, culture and organisational development Committee (August 2026), Workforce wellbeing and inclusion group (August 2026)

This report is for: ☒ Approval ☒ Assurance ☐ Discussion ☐ information

This report supports the following ambitions within the organisational strategy:

- ☐ High quality care ☐ Joined up services
- ☒ Empowered to improve ☐ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

This statutory report provides an overview, analysis and recommendations based on 2025/2026 Workforce Disability Equality Standard (WDES) data.

The data highlights the following areas as key priorities that must be addressed:

WDES Metric 1: representation

Whilst disability disclosure has increased to its highest recorded level (7.6%), 22% large number of the workforce still have no disability information recorded on ESR.

WDES Metric 3: capability

Disabled staff remain more than three times as likely as non-disabled staff to enter a formal capability process.

WDES Metrics 4a: bullying from patients

There has been an increase over the last two years for both disabled and non-disabled staff. Disabled staff continue to report significantly higher levels of harassment, bullying and abuse from patients than non-disabled staff.

WDES Metrics 4b and 4c: bullying from managers and colleagues

Levels of harassment, bullying and abuse remain consistently higher for disabled staff than non-disabled staff. Whilst there have been small improvements over the last year, the disparity in experience remains significant.

WDES Metric 7: feeling valued

The percentage of disabled staff who feel satisfied with the extent to which the Trust values their work has fallen to its lowest level in the past five years, and the gap between disabled and non-disabled staff has widened over the last year.

WDES Metric 9: staff engagement

Gradual downward trend over the last five years for all staff. The engagement scores for disabled staff are lower than non-disabled staff.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

The data, analysis and proposed next steps within this report are imperative for the Trust to understand, engage with and endorse to uphold our strategic and statutory commitments to equality, diversity and inclusion and staff standards.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*

The report highlights key priority areas where focus must be placed to improve outcomes and experiences for staff with a disability or long-term health condition and to address the identified inequities.

Actions to address these priority areas have already been embedded within the Trust's workforce inclusion plan and health and wellbeing plan.

Progress will be monitored through a combination of Workforce Disability Equality Standard (WDES) metrics, NHS Staff Survey results, workforce data, staff network feedback and regular reporting through Trust committees and groups. This will enable the Trust to assess the impact of improvement activity, identify emerging issues and ensure appropriate oversight and accountability.

Action required by the Group:

- Review the data presented within the report. Ensure that it has been analysed fully and the narrative within this report is informative, clear, and accessible for all.
- Approve the report and provide permission for it to be published both internally and externally.

Governance and compliance

Risk and assurance:

The completion and publishing of report upholds the Trust's WRES and WDES statutory requirements. There is a requirement for this report to be published by 31 October 2026.

Equality, diversity and inclusion:

The report is centred around identifying areas of inequity amongst staff with a disability or long-term health condition. In addition to uphold our statutory requirements, the ongoing and scheduled work to address these areas contribute towards the creation of an inclusive culture within our Trust, where all colleagues are empowered to improve and are supported to thrive.

Sustainability:

Creating an inclusive culture where staff with a disability or long-term health condition feel valued, supported and able to thrive contributes to both workforce and organisational sustainability. Addressing the inequalities identified within this report supports staff wellbeing, engagement, retention and career development, whilst helping to create a culture of belonging that enables the Trust to attract, retain and develop talent from the widest possible pool.

Legal and regulatory context:

No implications are noted. Completion of this report meets the Trust's statutory requirements.

Workplace Disability Equality Standard (WDES) report

2025/26

Contents

1. Context	7
2. Summary of key areas of work	9
Disability pay gap reporting	9
Make your profile count campaign	9
Launch of the Trust's menopause policy	10
Launch of the <i>Empower U</i> platform	11
Succession planning within the Staff Disability Network	11
3. West Suffolk NHS Foundation Trust WDES 2025-26 report key highlights	12
4. West Suffolk NHS Foundation Trust WDES 2024-25: the overall picture	14
5. 2025 WDES analysis	17
WDES Metric 1 - Percentage and number of staff by disability	17
WDES Metric 2 - The relative likelihood of non-disabled candidates compared to disabled candidates being appointed from shortlisting across all posts.	19
WDES Metric 3 - The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff	20
5 Year Comparison of WDES Indicators 1-3	20
WDES Metric 4a - Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	21
WDES Metric 4b - Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months.	22
WDES Metric 4c- Percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	23
WDES Metric 4d - Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work.	23
WDES Metric 5 - Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion	24
WDES Metric 6 - Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties.	25
WDES Metric 7 - Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work.	26
WDES Metric 8 - Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	27
WDES Metric 9 - Staff engagement scores	27
WDES Metric 10 - Disability representation among board members	28
6. Conclusion and next steps	29

7. Appendices	30
Appendix A: number and percentage of non-clinical and clinical staff by disability in 2024/2025	30
Appendix B: number and percentage of non-clinical and clinical staff by disability in 2025/26	31

1. Context

The NHS Workforce Disability Equality Standard (WDES) is published annually and is an essential tool in supporting the Trust to be an accessible, inclusive and fair workplace. It was introduced in 2019 and is built around 10 evidence-based measures (metrics) which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. This 2026 report is the latest version and uses data from March 2025 - March 2026.

Utilising data from the electronic staff record (ESR) and the NHS Staff Survey, this report helps evaluate progress and identify areas where further improvement is needed to recognise and address bias within our processes, tackle unacceptable behaviours, eliminate the disparity of experiences evident between disabled and non-disabled staff, and support disabled staff to thrive at work. This is important because studies show that a motivated and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

Themes that have been identified across the NHS from analysis of all Trust's WDES data show that disabled NHS staff are:

- More likely to go through performance management capability processes.
- More likely to experience harassment, bullying or abuse.
- Less likely to feel that they have equal opportunities for career progress or promotion.
- More likely to feel pressured to attend work.
- Less likely to feel valued for their contribution to the organisation.
- Less likely to feel engaged.
- Less likely to be appointed through shortlisting.

This year's WSFT WDES report unfortunately highlights little progress over the past year and instead signifies the challenges we still face and must strengthen work on.

We know that, to achieve the goals set out for our staff in the 10 Year Health Plan, we must enhance the experience of our workforce, improve retention and attract new talent to the Trust from the widest possible pool, alongside working to eliminate the disparities in the experiences between staff with a disability or long-term health condition, and those without. With nearly 1 in 4 people working in the NHS having lived experience of a disability or long-term condition, our journey toward achieving equity is ongoing and this report represents an important step in holding the Trust accountable, ensuring transparency, and driving the systemic change needed for a more inclusive future.

The following page highlights a shortened summary of some of the key areas of work and achievements we have undertaken that are contributing towards a more equitable and inclusive organisation.

2. Summary of key areas of work

Disability pay gap reporting

The report, run using data as at 31st March 2026, showed a mean disability pay gap (DPG) of 6.11 and a median DPG of 7.63, meaning the average pay for disabled colleagues is higher than non-disabled colleagues. Both the mean and median DPG decreased from the previous year (7.44% and 8.75%, respectively).

There continues to be two significant barriers within this area of work:

1. High 'non-disclosure' rates. This means that a large percentage of our colleagues have not shared or updated their EDI information (specifically, in this case, their information regarding any disabilities or long-term health conditions they may or may not have) with the organisation through ESR. Although there have been improvements over the last year, there is further work to be done.
2. The options on ESR are conflicting, and having multiple options is a barrier preventing the streamlining and accurate interpretation of our data. ESR is a national workforce system and amendments to address this barrier cannot be implemented locally.

Make your profile count campaign

The aim of this campaign was to increase the number of staff who had updated their EDI data through their Electronic Staff Record (ESR) profile.

This was identified as a key priority arising from several Trust data sources, particularly in relation to disability as high levels of non-disclosure present a problem as it limits the ability to draw robust conclusions from our data.

The campaign saw an increase of staff disclose and update their disability data through the available categories on ESR.

This can be observed by the data in Table 1, which shows that the number of staff responding 'yes' and 2025-2026 has increased since 2024-25, and the number of staff responding 'no', 'undefined' or 'not declared' has decreased since 2024-25. The number of staff responding 'prefer not to answer' has slightly increased.

The number of staff who have declared a disability is the highest since at least 2022/23, and the number of staff who have not declared a disability or shared any disability information ('not declared' or 'undefined') is also the lowest it has been since at least 2022/23.

The campaign also resulted in an increase in staff sharing their armed forces, socio-economic background and working carer data through ESR.

Whilst this campaign has made an impactful and positive start, there is more work to be done to continue to increase EDI disclosure for disability and other characteristics.

Table 1: The number of staff in post each in 2024/2025 and 2025/2026

Disability	2022/2023	2023/2024	2024/25	2025/26	Comments
No	3,164	3,530	3,815	3,747	
Not declared	332	366	334	286	It should be noted that, whilst these three categories are separate on ESR and we report on these as such internally, within WDES reports, data from these three categories are combined and recorded under the category of ' <i>not disclosed</i> '. This can be seen in Tables 3,4 and 5.
Undefined	1,088	902	851	656	
Prefer not to answer	354	314	217	234	
Yes	280	349	270	406	
Total	5,218	5,461	5,487	5,329	

Source: Electronic Staff Record (as at 1 April 2026)

Launch of the Trust's menopause policy

The policy, launched during International Women's Week 2026, aims to ensure anyone experiencing menopause, perimenopause, or post-menopause feels supported, included, and empowered.

The policy includes:

- Clear guidance for colleagues and managers
- Inclusive support for colleagues who are trans and non-binary and experiencing the menopause
- Support on how to have confidential conversations and make flexible, person-centred adjustments
- Training and resources for all staff
- Access to Menopause Advocates, Occupational Health, and wellbeing support.

Launch of the *Empower U* platform

The platform *Empower U* launched in June 2026 brings together reward, recognition, and health and wellbeing support in one place. It also provides a space to acknowledge, celebrate and share praise for the work staff do every day across all areas of the Trust.

Succession planning within the Staff Disability Network

The Trust's Staff Disability Network took part in a pilot to test the use of a succession planning tool designed to support leadership development, nurture diverse talent, create opportunities for development, and strengthen the long-term sustainability of the network.

Key elements of the pilot included:

- Outlining the important role the network plays in supporting the delivery of the Trust's *Empowered to Improved* strategic ambition
- Developing a candidate brief that outlined the purpose of the network, the role of the co-chair and the skills, knowledge and behaviours required for the position. The brief included a person specification aligned to the Trust's values and outlined both essential and desirable criteria.
- Creating an expression of interest process to enable members to indicate that they were interested in either becoming a co-chair of the network or supporting the network through another leadership role.
- Delivering an information session for network members interested in finding out more about the opportunity.
- Holding informal discussions with applicants to explore their aspirations for the network, understand the skills and experiences they could bring to the role, discuss any support requirements, and ensure they had the support and approval of their line manager.
- Facilitating a structured handover between the outgoing network chair and the incoming co-chairs to support continuity and knowledge transfer.

As a result of the pilot, the Network successfully appointed two new co-chairs in June 2026. The pilot has also provided valuable learning that has since been incorporated within additional pilots testing the succession planning framework in other areas of the workforce.

3. West Suffolk NHS Foundation Trust WDES 2025-26 report key highlights

Performing well

WDES Metric 2: shortlisting

For the third consecutive year, the relative likelihood score is 1, which indicates that there is equity between disabled and non-disabled applicants appointed from shortlisting.

Maintain focus- improvement required

WDES Metric 5: career progression

Disabled staff are less likely to believe the Trust provides equal opportunities for career progression and promotion than non-disabled staff.

WDES Metric 6: presenteeism

Little improvement over the last five years, although the percentage of both disabled and non-disabled staff feeling pressure from their manager to work despite not feeling well enough to perform their duties is lower than benchmarked Trusts.

WDES Metric 8: workplace adjustments

Year-on-year decline in the percentage of disabled staff reporting that reasonable adjustments have been made. The trust remains below the average percentage of peer Trusts.

Work required- priority areas

WDES Metric 1: representation

Whilst disability disclosure has increased to its highest recorded level (7.6%), 22% large number of the workforce still have no disability information recorded on ESR.

WDES Metric 3: capability

Disabled staff remain more than three times as likely as non-disabled staff to enter a formal capability process.

WDES Metrics 4a: bullying from patients

There has been an increase over the last two years for both disabled and non-disabled staff. Disabled staff continue to report significantly higher levels of harassment, bullying and abuse from patients than non-disabled staff.

WDES Metrics 4b and 4c: bullying from managers and colleagues

Levels of harassment, bullying and abuse remain consistently higher for disabled staff than non-disabled staff. Whilst there have been small improvements over the last year, the disparity in experience remains significant.

WDES Metric 7: feeling valued.

The percentage of disabled staff who feel satisfied with the extent to which the Trust values their work has fallen to its lowest level in the past five years, and the gap between disabled and non-disabled staff has widened over the last year.

WDES Metric 9: staff engagement

Gradual downward trend over the last five years for all staff. The engagement scores for disabled staff are lower than non-disabled staff.

4. West Suffolk NHS Foundation Trust WDES 2024-25: the overall picture

When considering our journey towards disability inclusion and equity, it is important to look at our WDES data over time. This gives a fuller picture of how things are changing and looks beyond year-on-year fluctuations that can be due to chance or short-term organisational changes. When a single metric goes up or down each year by a small amount, this is unlikely to indicate an improving/declining trend and instead suggests there has been no significant improvement/decline. The table below provides a transparent summary of our progress since initial reporting, which is explained in more detail throughout this report.

Table 2: A five-year overview, further information and work in progress for each WDES metric

Area	5-year view	Further information
Metric 1: Representation	Increasing disability disclosure	As highlighted in table 6, the proportion of staff declaring a disability or long-term health condition has increased steadily from 3.8% in 2021/22, to 7.6% in 2025/26. Whilst this demonstrates progress, 22% of the workforce still have no disability information recorded on ESR. Additionally, there continues to be a significant difference between the percentage of staff who have shared that they have a disability or long-term health condition within the Trust's NHS 2025 staff survey results (24% of respondents) in comparison to Trust ESR data (7.6% of staff).
Metric 2: Shortlisting	Sustained equity between disabled and non-disabled applicants	The relative likelihood score is 1, which suggests equitable appointments of disabled and non-disabled candidates from the shortlisting stage.
Metric 3: Capability	Slight improvement from 2024/25 but inequity remains	The relative likelihood of disabled staff entering the formal capability process decreased from 3.9 to 3.1 during 2025/26. Whilst this represents improvement, disabled staff remain more than 3 times as likely to enter a formal capability process than non-disabled staff.

Metric 4a: Harassment, bullying and abuse from patients	Overall improvement since 2020 but recent deterioration	There has been an increase of staff who have experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months for both staff with and without a disability. Disabled staff continue to report higher levels than non-disabled staff and, for the first time in at least five years, both staff groups have scored slightly worse than benchmarked Trusts.
Metric 4b: Harassment, bullying and abuse from managers	Recent improvement, but disabled staff continue to experience disproportionately higher levels	The percentage of disabled staff experiencing harassment, bullying or abuse from managers has decreased over the last year (16.4% in 2024/25 to 15.3% in 2025/26). However, disabled staff continue to report significantly high levels than non-disabled staff (10.7% in 2024/25 and 8.5% in 2025/26), indicating an ongoing disparity in experience
Metric 4c: Harassment, bullying and abuse from other colleagues	Little improvement for disabled staff and persistent disparity between disabled and non-disabled staff	Although the percentage of disabled staff who have experienced harassment, bullying or abuse from other colleagues has slightly decreased over the last year (from 26.5% in 2024/25 to 25.4% in 2025/26), the percentage remains significantly higher for disabled staff when compared to non-disabled staff (13.6% in 2025/26).
Metric 4d: Reported incident of harassment, bullying or abuse	Declining reporting rates amongst disabled staff	The percentage of staff with a disability reporting an incident of harassment has decreased from 51.1% in 2024 to 48.2% in 2025. It is worth noting that 2025 percentages for disabled staff have increased from where they were in 2021 notably from 2021 and 2022, where they were 45.6% and 47%, respectively. The percentage of non-disabled staff reporting an incident of harassment, bullying or abuse experienced at work has significantly increased since 2021, where it was 42.8%. There has been a +3.8% increase in the percentage of non-disabled staff who have reported their experience of harassment, bullying or abuse (from 47.3% to 51.1%).
Metric 5: Career progression	<i>Due to a change in the wording of the 2025 NHS staff survey question, previous data is not reported as it is not comparable</i>	The percentage of disabled staff who believe that the Trust provides equal opportunities for career progression or promotion is significantly lower than the percentage of non-disabled staff who believe this (43.7% and 53.7%, respectively).

Metric 6: Feeling pressured to come to work when unwell	Negligible movement for disabled staff, very small decrease for non-disabled staff	When looking at the percentage of disabled staff who feel pressure from their manager to come to work despite not feeling well enough to perform their duties, there has been negligible overall change between 2021 (26%) and 2025 (25.9%). Amongst non-disabled staff, there has been a small overall decline between 2021 (19.9%) and 2025 (18.1%). The gap between the two staff groups has widened over the last year.
Metric 7: Feeling valued	Long-term decline with growing disparity	An overall 5-year downward trend for both the percentages of disabled and non-disabled staff feeling satisfied with the extent to which the organisation values their work. For disabled staff, 2025 data highlighted this as the lowest point in at least the last five years (28.6%). Whilst the percentage of non-disabled staff increased marginally, this percentage (39.2%) is still much lower in comparison to the percentage 5 years ago (47.1%).
Metric 8: Workplace adjustments	Decreasing trend for disabled colleagues	The percentage of staff with a disability or long-term condition saying the Trust has made reasonable adjustment(s) has declined for a third consecutive year. The Trust remains below the benchmark average for comparable Trusts.
Metric 9: Staff engagement	Gradual decline, particularly amongst disabled staff	Except for 2023, which saw a percentage increase for both disabled and non-disabled staff, there has been a small, steady decline each year in staff engagement scores for both disabled and non-disabled staff. For the second consecutive year, the percentage score for disabled colleagues has fallen below the average of peer Trusts.
Metric 10: Board representation	Statis, but with ongoing disclosure challenges	Board level representation of disability remains the same. A proportion of Board members continue to have undisclosed disability status, meaning opportunities remain to improve transparency and confidence in disclosure at senior levels of the organisation.

5. 2025 WDES analysis

WDES Metric 1 - Percentage and number of staff by disability

The WSFT workforce snapshot of 31 March 2026 showed that the Trust had a workforce of 5339 (a decrease from the previous year: 5508), of which 7.6% of staff disclosed a disability or long-term condition (a 1.1% increase of disability disclosure since the previous year). Data also showed that 22% of staff had not shared or disclosed their disability data. This has decreased from 25.1% at March 2025, and 29% at March 2024. Whilst this consistent increase of disclosure has is positive, the percentage of the workforce who have not shared or updated their disability information remains very high at over 20% and highlights a key priority for the Trust.

Table 3 is a snapshot of WSFT staff by disability status as of 31 March 2025/26 compared to 2024/25.

Table 3: number and percentage of all staff by disability status in 2024/25 and 2025/2026

Band	2024/25					2025/2026				
	Disabled	Non - disabled	Disability unknown	Total number of staff at each band	% of disabled staff at band	Disabled	Non-disabled	Disability unknown	Total number of staff at each band	% of disabled staff at band
1	0	5	4	9	0%	0	0	0	0	0%
2	0	366	98	464	0%	38	356	82	476	8%
3	31	672	209	912	3.4%	99	663	162	924	10.7%
4	102	408	126	636	16%	52	386	104	542	9.6%
5	48	676	232	956	5%	70	668	186	944	7.4%
6	54	609	231	894	6%	53	621	210	884	6%
7	48	413	191	652	7.4%	45	412	161	618	7.3%
8a	37	160	58	255	14.5%	15	166	51	232	6.5%
8b	11	53	18	82	13.4%	3	50	12	65	4.6%
8c	4	20	11	35	11.4%	4	26	8	38	10.5%
8d	2	8	3	13	15.4%	2	8	3	13	15.4%
9	2	5	4	11	18.2%	0	7	3	10	0%
VSM	1	3	1	5	0%	1	4	2	7	14.3%
Trainee Grade	7	62	101	170	4.1%	6	66	112	184	3.3%
Non-consultant career grade	1	113	25	139	0.7%	5	110	23	138	3.6%
Consultant	13	190	72	275	4.7%	14	192	58	264	5.3%
Total	361	3763	1384	5508	6.5%	407	3735	1177	5339	7.6%

NB: Appendix A shows the breakdown of clinical v non-clinical staff in 2024/25 and 2025/26, respectively.

Whilst disability disclosure across the Trust increased from 6.5% to 7.6%, this improvement was not reflected consistently across all pay bands. Disability representation at Band 8a decreased from 14.5% to 6.5% over the last year, whilst representation at Band 8b decreased from 13.4% to 4.6%.

This reduction is disproportionate when compared with changes amongst non-disabled staff at these grades. At Band 8a, the number of non-disabled staff increased slightly over the last year (from 160 to 166, respectively), whilst the number of disabled staff reduced by almost 60% (from 37 to 15). Similarly, at Band 8b, the number of disabled staff reduced from 11 in 2024/25 to 3 in 2025/26 despite minimal change to the number of non-disabled staff (-3).

While the relatively small numbers within Bands 8a and 8b mean that year-on-year changes should be interpreted with caution, the data highlights a large reduction in disability representation across these senior leadership roles over the last year. Further exploration is required to understand the factors contributing to this reduction.

WDES Metric 2 - The relative likelihood of non-disabled candidates compared to disabled candidates being appointed from shortlisting across all posts.

Table 4: the number of shortlisted applicants by disability status, the number of appointed applicants from shortlisting by disability status, and the relative likelihood of non-disabled applicants being being appointed in comparison to disabled applicants across the following years: 2023/24, 2024/25 and 2025/2026.

	2023/24			2024/25			2025/26		
	Disabled	Non Disabled	Disability Unknown	Disabled	Non Disabled	Disability Unknown	Disabled	Non Disabled	Disability Unknown
Number of shortlisted applicants	211	2986	107	194	2436	58	204	2302	121
Number appointed from shortlisting	13	193	24	13	223	22	40	476	14
Relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled Staff	1			1			1		

The score of 1 indicates equity between disabled and non-disabled candidates in relation to appointment from shortlisting.

WDES Metric 3 - The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.

Table 5: the number of staff entering a formal capability process by disability status, the number of disabled and non-disabled people entering this process due to ill health, and the relative likelihood of disabled staff entering a formal capability process across the following years: 2023/24, 2024/2025 and 2025/2026.

	2023/24			2024/25			2025/2026		
	Disabled	Non-Disabled	Disability Unknown	Disabled	Non-Disabled	Disability Unknown	Disabled	Non-Disabled	Disability Unknown
Average No. of staff entering formal capability process over the last 2 years	2	10	0	7	8	1	1	3	1
Of these, how many were on the grounds of ill-health	0	0	0	4	0	0	0	0	0
Relative likelihood of Disabled Staff entering formal capability	2			3.9			3.1		

Although the figure has slightly decreased over the last year, an overall increasing trend can be seen over the last 3 years. The score remains much higher than 1, which indicates that disabled staff are significantly more likely to enter the formal capability process in comparison to non-disabled staff.

5 Year Comparison of WDES Indicators 1-3

The table below is a 5-year comparison of metrics 1-3. Metric 1 shows a slow increase in the number of staff disclosing a disability between March 2022 and March 2026. Whilst this increase is positive, the number of staff who do not have any disability data recorded within ESR remains very large and equates to 22% of our workforce. Reducing this percentage by encouraging staff to update their information strengthens our data and enables us to better understand our workforce. This remains a key priority for the Trust. Metric 2 indicates equity between disabled and non-disabled candidates in relation to the relative likelihood of appointment from shortlisting. Metric 3 has

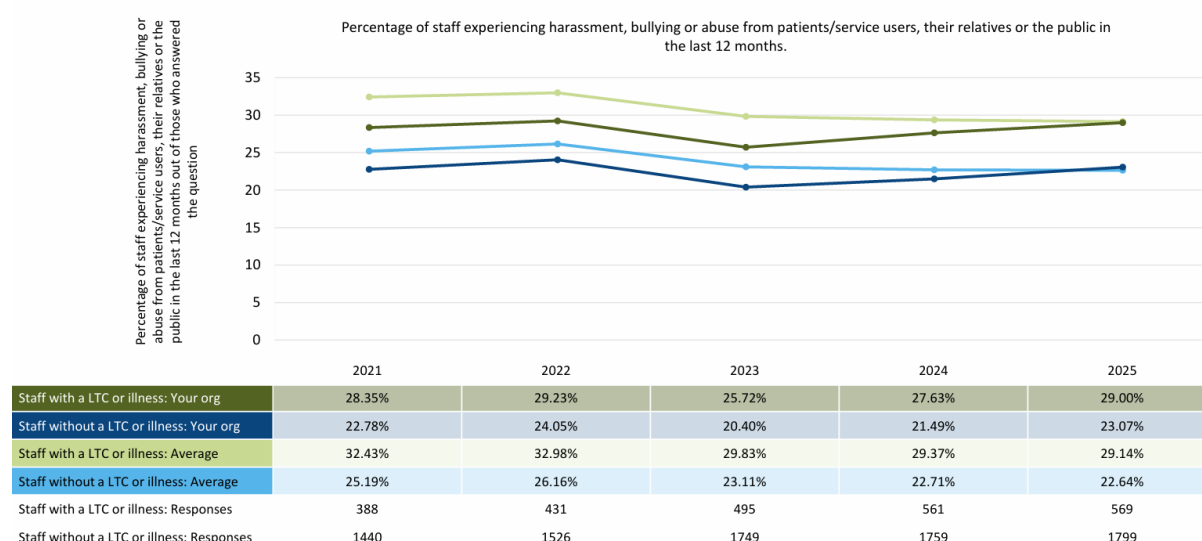
slightly decreased this year by 0.8, although it continues to highlight a greater likelihood that staff with a disability enter a formal capability process in comparison to non-disabled staff. This further action is required to turn the dial towards equity.

Table 6: a five-year comparison of WDES indicators 1-3

		2021/22	2022/23	2023/24	2024/25	2025/2026
Metric 1	No. of staff at the Trust	5631	5214	5409	5507	5339
	No (%) of staff with a disability/LTC at the Trust	212 (3.8%)	278 (5.3%)	354 (6.5%)	364 (6.6%)	407 (7.6%)
Metric 2	Relative likelihood of non-disabled staff appointed from shortlisting compared to disabled staff	0.63	0.39	1.0	1.4	1.0
Metric 3	Relative likelihood of disabled staff entering formal capability process compared to non-disabled staff	14.4	0	2	3.9	3.1

The data for metrics 4-9 have been sourced from the National NHS Staff Survey which provides a comparison of the outcomes of the response for disabled and non-disabled staff: [Local results for every organisation | NHS Staff Survey \(nhsstaffsurveys.com\)](https://nhsstaffsurveys.com)

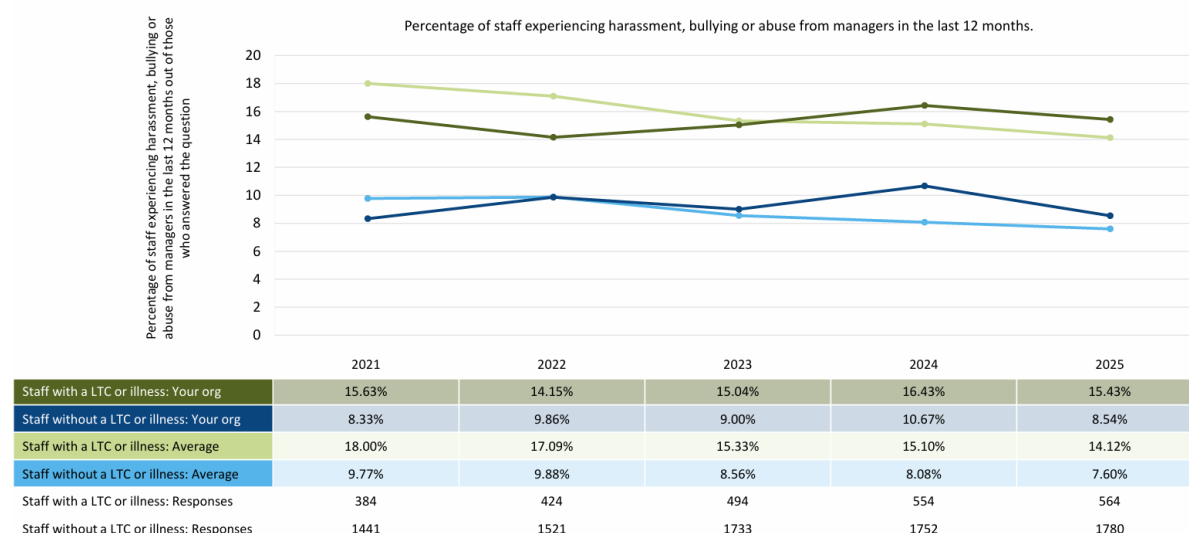
WDES Metric 4a - Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.



Data shows an increase in the percentage of staff who have experienced harassment, bullying or abuse from patients, relatives, or the public for both staff with and without a disability. The percentage remains higher for staff with a disability compared to staff

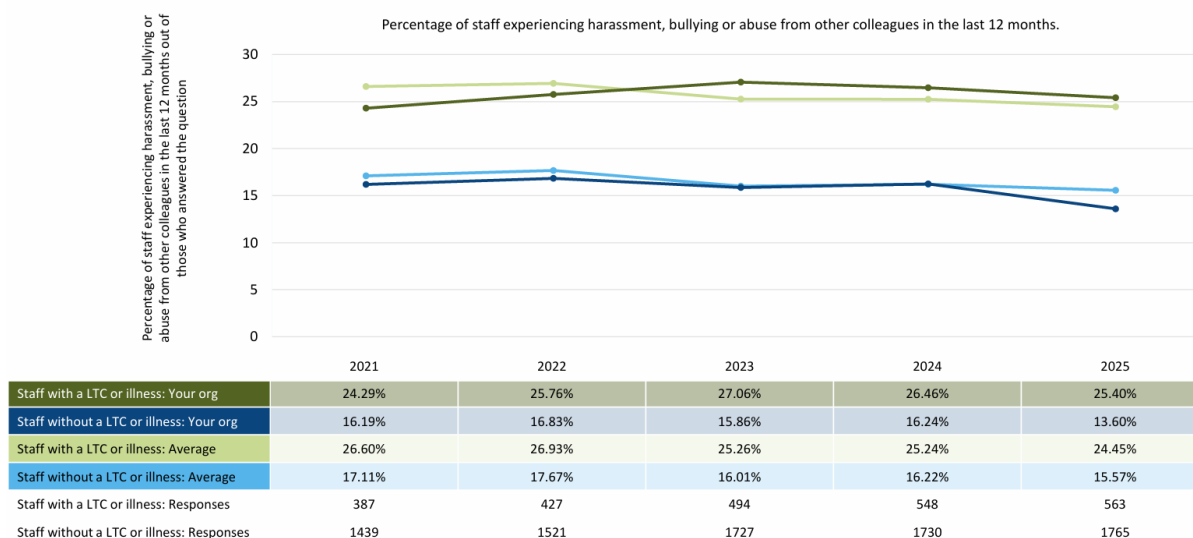
without a disability. For this first time in at least five years, the percentage of both disabled staff and non-disabled staff who have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months is slightly higher than the average when benchmarked against other similar Trusts.

WDES Metric 4b - Percentage of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months.



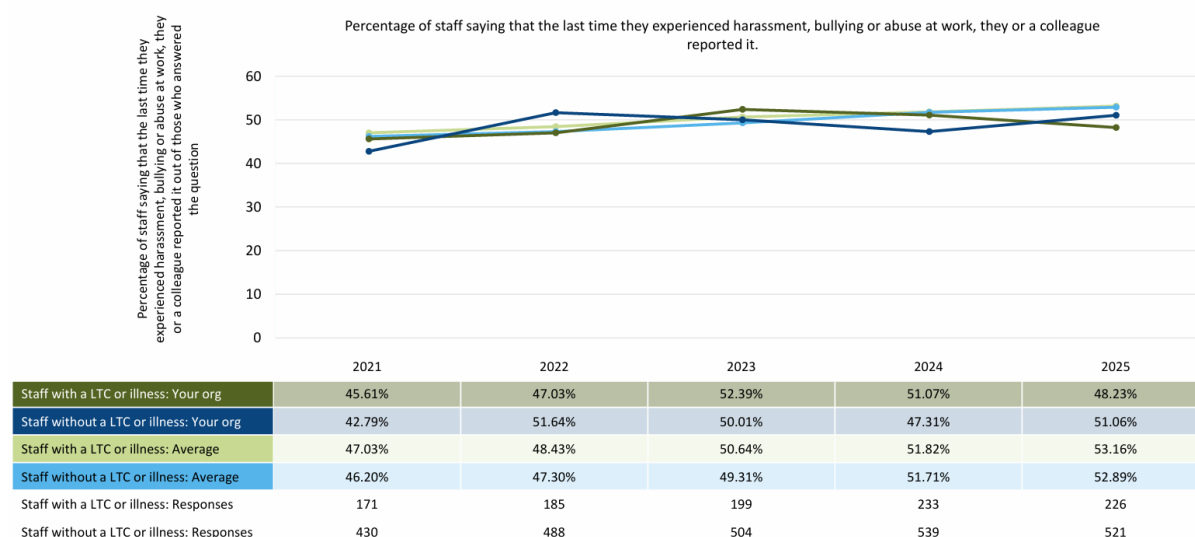
There has been a decrease in the percentage of staff who have experienced harassment, bullying or abuse from managers for staff with and without a disability. The percentage remains higher for staff with a disability compared to staff without a disability.

WDES Metric 4c- Percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.



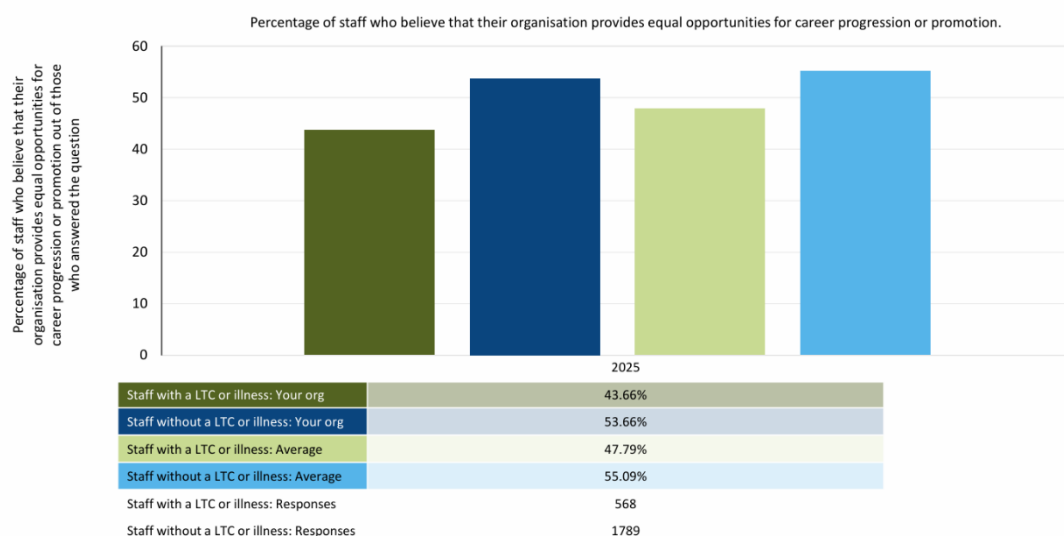
There has been a small decrease in the percentage of staff with a disability who have experienced harassment, bullying or abuse from other colleagues, and a larger decrease amongst non-disabled staff. The percentage remains much higher for staff with a disability compared to staff without a disability.

WDES Metric 4d - Percentage of disabled staff who indicated that they or a colleague reported the last incident of harassment, bullying or abuse experienced at work.



There has been a decrease in the percentage of disabled staff reporting an incident of harassment, bullying or abuse experienced at work and an increase of non-disabled staff reporting these incidences.

WDES Metric 5 - Percentage of disabled staff believing that their trust provides equal opportunities for career progression or promotion.

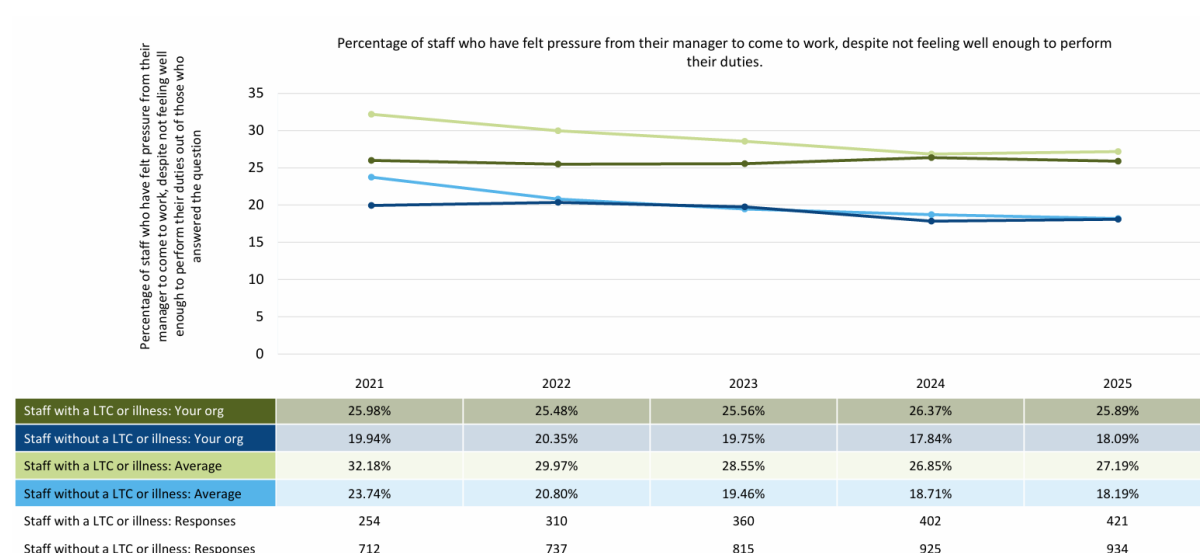


Note: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 (Q15) are not reported. For more information, please refer to the Technical Guide: <https://www.nhsstaffsurveys.com/survey-documents/>

This data highlights that a larger percentage of non-disabled staff believe that the Trust provides equality opportunities for career progression or promotion in comparison to disabled staff. This data for both disabled and non-disabled staff, is lower than the average when benchmarked against other similar Trusts.

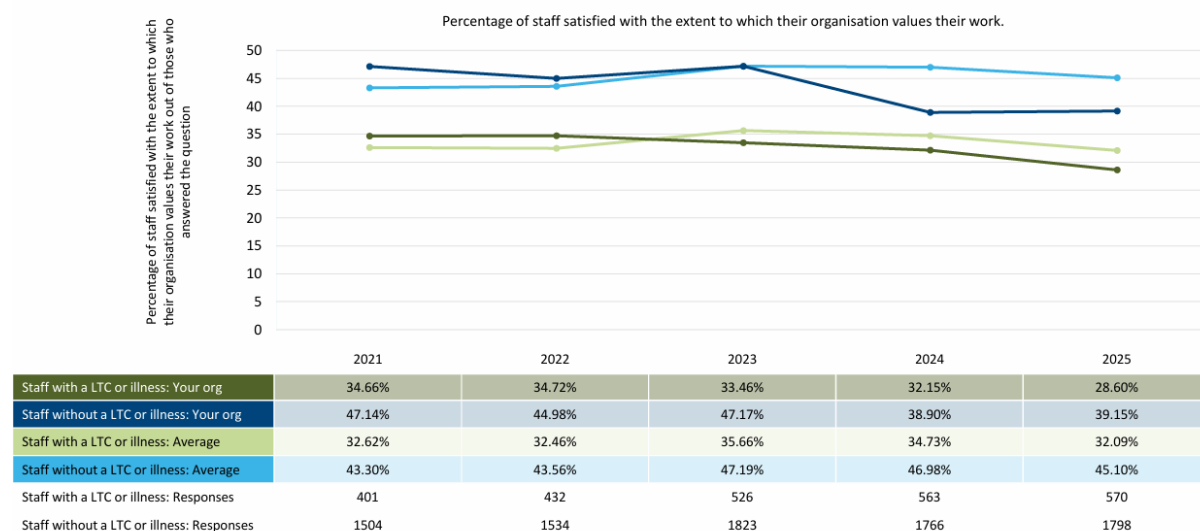
It should be noted that, due to changes in the wording of this question during the 2025 staff survey, previous year's results are not reported as they are not comparable.

WDES Metric 6 - Percentage of disabled staff who said that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties.



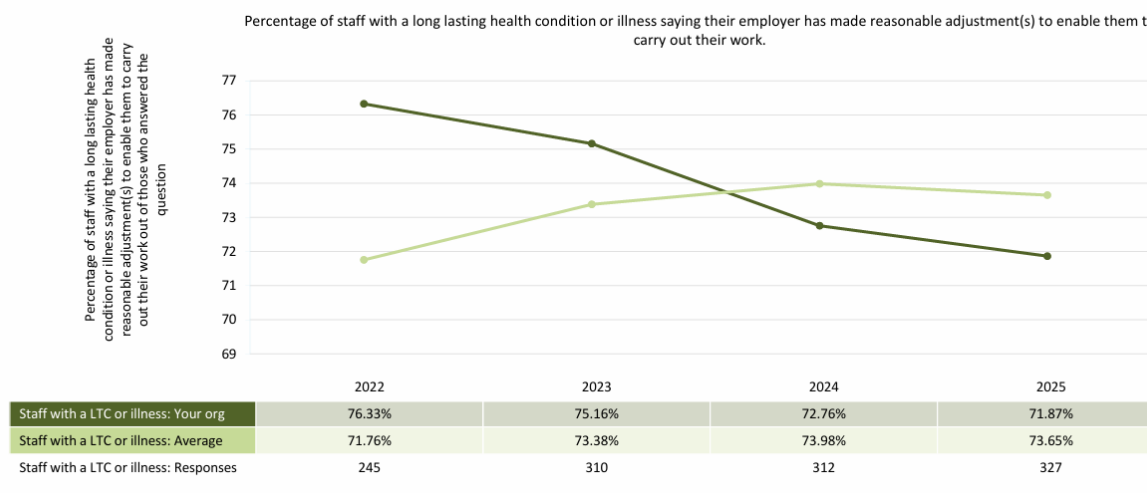
The data shows a slightly lower percentage of staff with a disability feeling pressure to come to work despite not feeling well enough to perform their duties in comparison to last year. Conversely, the percentage of non-disabled staff feeling this way has slightly increased.

WDES Metric 7 - Percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work.



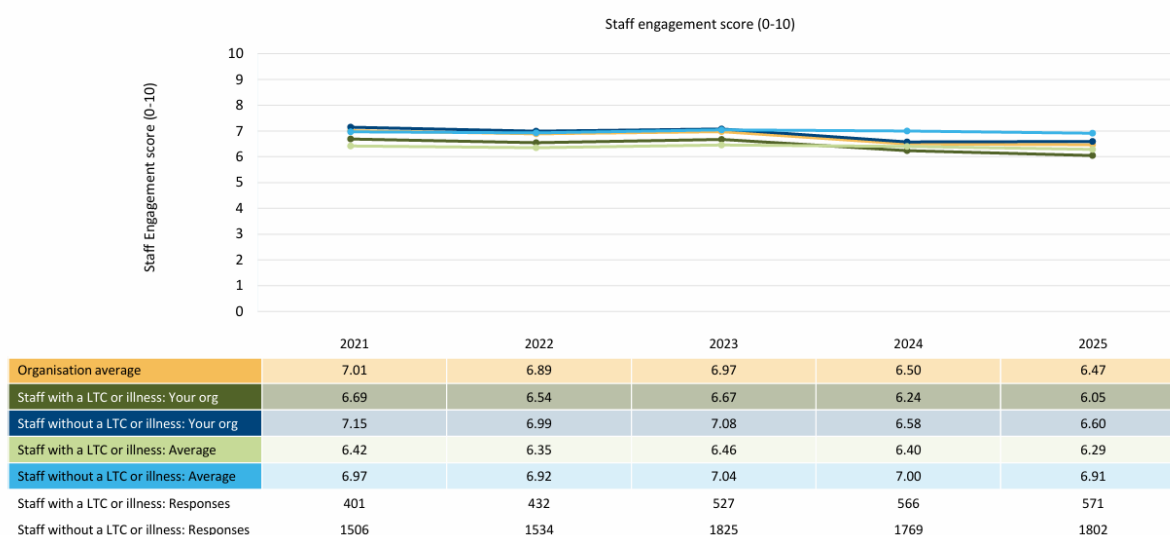
The percentage of staff with a disability feeling satisfied with the extent to which the organisation values their work has decreased in the past year by -3.6%, and it is now the lowest it has been since at least 2021. Although the percentage for non-disabled staff has increased marginally in the past year (+0.3%), the current percentage remain significantly lower than the percentages in 2021, 2022 and 2022. The percentage difference between disabled staff and non-disabled staff has widened in the last year (10.6% in comparison to 6.75%, respectively).

WDES Metric 8 - Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.



The percentage of staff with a disability or long-term condition saying the Trust has made reasonable adjustment(s) has decreased slightly in the last year but reflects a trend where this percentage is decreasing year-on-year.

WDES Metric 9 - Staff engagement scores



The engagement score has declined slightly for disabled staff and remained the same for non-disabled staff. There has been a small, steady decline since 2020 (except for 2023).

WDES Metric 10 - Disability representation among board members

Table 7: the number of Executive and Non-Executive board members by disability status , and the number of voting and non-voting board members by disability status over the following four years: 2023, 2024, 2025 and 2026.

		2023	2024	2025	2026
Executive Board	Disability	0	0	1	1
	No disability	5	6	3	4
	Not disclosed	2	0	3	2
Non-Executive	Disability	1	1	1	1
	No disability	4	6	6	4
	Not disclosed	5	0	3	2
Total		17	13	17	14

		2023	2024	2025	2026
Voting	Disability	1	1	2	2
	No disability	7	12	9	8
	Not disclosed	7	0	6	4
Non-Voting	Disability	0	0	0	0
	No disability	1	0	0	0
	Not disclosed	1	0	0	0
Total		17	13	17	14

Board level representation of members with a disability remains consistent.

6. Conclusion and next steps

This report demonstrates areas of positive progress, both in terms of sustained improvement over time and progress achieved during the last year. However, persistent disparities remain between the experiences of disabled and non-disabled staff, particularly in relation to capability processes, harassment and bullying, feelings of value, workplace adjustments and staff engagement.

The Trust's approach to advancing disability inclusion is not limited to the annual WDES reporting process. Key priorities are embedded within the *Empowered to Improve* ambition of the Trust's 2025-2028 Strategic Plan and supported through delivery of the Trust's workforce inclusion plan, the workforce health and wellbeing plan, and wider people and culture programmes.

Progress is monitored through a combination of WDES metrics, NHS Staff Survey results, workforce data and staff network feedback and regular reporting to Trust committees and groups, ensuring ongoing oversight and accountability. This work is further supported by the NHS Staff Standards, which provides a framework for creating compassionate, inclusive and psychologically safe workplaces where all staff feel valued, respected, have equitable opportunities to succeed and are supported to thrive.

It must be recognised that achieving disability equity is a long-term commitment. While improvements are expected over time, some of the disparities identified within this report may take several years to address and reduce fully. The focus during 2026/27 will therefore be on sustaining progress, embedding inclusive practices, and ensuring that improvement activity is targeted towards the areas of greatest need. Success will be measured through trends over time rather than year-on-year fluctuations alone.

The following areas have been identified as priorities for 2026/27. Actions to progress these areas are embedded within the Trust's workforce inclusion plan and the workforce health and wellbeing plan:

- Increasing disability disclosure and improving data quality
- Reducing inequity within formal capability processes
- Reducing experiences of harassment, bullying and abuse
- Improving access to and experiences of workplace adjustments
- Increasing feelings of value amongst disabled staff
- Improving staff engagement and experience
- Improving disability representation within senior leadership roles
- Strengthening inclusion, belonging and psychological safety in line with the NHS Staff Standards

7. Appendices

Appendix A: number and percentage of non-clinical and clinical staff by disability in 2024/2025

		Snapshot of data as at 31st MARCH 2025						
		Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall
	Measure	# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/Null	% Unknown/Null	Total
1b) Clinical Staff								
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	5	4.24%	98	83.05%	15	12.71%	118
Bands 3	Headcount	71	10.52%	467	69.19%	137	20.30%	675
Bands 4	Headcount	16	7.21%	159	71.62%	47	21.17%	222
Bands 5	Headcount	40	4.97%	561	69.69%	204	25.34%	805
Bands 6	Headcount	44	5.51%	549	68.71%	206	25.78%	799
Bands 7	Headcount	26	4.79%	356	65.56%	161	29.65%	543
Bands 8a	Headcount	6	4.29%	89	63.57%	45	32.14%	140
Bands 8b	Headcount	1	3.03%	25	75.76%	7	21.21%	33
Bands 8c	Headcount	0	0.00%	7	53.85%	6	46.15%	13
Bands 8d	Headcount	0	0.00%	2	100.00%	0	0.00%	2
Bands 9	Headcount	0	0.00%	1	50.00%	1	50.00%	2
VSM	Headcount	0	0.00%	1	100.00%	0	0.00%	1
Other. Please specify in notes.	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	92	9.1%	724	71.3%	199	19.6%	1015
Cluster 2: AfC bands 5 to 7	Auto-Calculated	110	5.1%	1466	68.3%	571	26.6%	2147
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	7	4.0%	114	65.9%	52	30.1%	173
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	11	61.1%	7	38.9%	18
Total Clinical	Auto-Calculated	209	6.2%	2315	69.0%	829	24.7%	3353
1a) Non Clinical Staff								
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	0	0.0%	5	55.6%	4	44.4%	9
Bands 2	Headcount	26	6.9%	268	71.1%	83	22.0%	377
Bands 3	Headcount	31	10.1%	205	66.6%	72	23.4%	308
Bands 4	Headcount	32	8.9%	249	69.2%	79	21.9%	360
Bands 5	Headcount	14	8.9%	115	73.2%	28	17.8%	157
Bands 6	Headcount	4	4.5%	60	67.4%	25	28.1%	89
Bands 7	Headcount	11	11.2%	57	58.2%	30	30.6%	98
Bands 8a	Headcount	5	5.6%	71	79.8%	13	14.6%	89
Bands 8b	Headcount	3	7.1%	28	66.7%	11	26.2%	42
Bands 8c	Headcount	2	10.0%	13	65.0%	5	25.0%	20
Bands 8d	Headcount	2	18.2%	6	54.5%	3	27.3%	11
Bands 9	Headcount	0	0.0%	4	57.1%	3	42.9%	7
VSM	Headcount	1	25.0%	2	50.0%	1	25.0%	4
Other. Please specify in notes.	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	89	8.4%	727	69.0%	238	22.6%	1054
Cluster 2: AfC bands 5 to 7	Auto-Calculated	29	8.4%	232	67.4%	83	24.1%	344
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	8	6.1%	99	75.6%	24	18.3%	131
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	5	11.9%	25	59.5%	12	28.6%	42
Total Non-Clinical	Auto-Calculated	131	8.3%	1083	68.9%	357	22.7%	1571

Appendix B: number and percentage of non-clinical and clinical staff by disability in 2025/26

		Snapshot of data as at 31st MARCH 2026						
		Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall
	Measure	# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/Null	% Unknown/Null	Total
1a) Non Clinical Staff								
Bands 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 2	Headcount	26	7.4%	257	73.6%	66	18.9%	349
Bands 3	Headcount	31	12.6%	165	66.8%	51	20.6%	247
Bands 4	Headcount	32	9.7%	238	71.9%	61	18.4%	331
Bands 5	Headcount	18	11.8%	107	70.4%	27	17.8%	152
Bands 6	Headcount	6	7.1%	56	66.7%	22	26.2%	84
Bands 7	Headcount	13	14.3%	54	59.3%	24	26.4%	91
Bands 8a	Headcount	5	6.4%	62	79.5%	11	14.1%	78
Bands 8b	Headcount	2	5.7%	27	77.1%	6	17.1%	35
Bands 8c	Headcount	3	13.6%	16	72.7%	3	13.6%	22
Bands 8d	Headcount	2	18.2%	7	63.6%	2	18.2%	11
Bands 9	Headcount	0	0.0%	5	62.5%	3	37.5%	8
VSM	Headcount	1	20.0%	2	40.0%	2	40.0%	5
Other. Please specify in notes.	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	89	9.6%	660	71.2%	178	19.2%	927
Cluster 2: AfC bands 5 to 7	Auto-Calculated	37	11.3%	217	66.4%	73	22.3%	327
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	7	6.2%	89	78.8%	17	15.0%	113
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	6	13.0%	30	65.2%	10	21.7%	46
Total Non-Clinical	Auto-Calculated	139	9.8%	996	70.5%	278	19.7%	1413
1b) Clinical Staff								
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	12	9.45%	99	77.95%	16	12.60%	127
Bands 3	Headcount	68	10.04%	498	73.56%	111	16.40%	677
Bands 4	Headcount	20	9.48%	148	70.14%	43	20.38%	211
Bands 5	Headcount	52	6.57%	581	73.36%	159	20.08%	792
Bands 6	Headcount	47	5.88%	565	70.63%	188	23.50%	800
Bands 7	Headcount	32	6.07%	358	67.93%	137	26.00%	527
Bands 8a	Headcount	10	6.49%	104	67.53%	40	25.97%	154
Bands 8b	Headcount	1	3.33%	23	76.67%	6	20.00%	30
Bands 8c	Headcount	1	6.25%	10	62.50%	5	31.25%	16
Bands 8d	Headcount	0	0.00%	1	50.00%	1	50.00%	2
Bands 9	Headcount	0	0.00%	2	100.00%	0	0.00%	2
VSM	Headcount	0	0.00%	2	100.00%	0	0.00%	2
Other. Please specify in notes.	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	100	9.9%	745	73.4%	170	16.7%	1015
Cluster 2: AfC bands 5 to 7	Auto-Calculated	131	6.2%	1504	71.0%	484	22.8%	2119
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	11	6.0%	127	69.0%	46	25.0%	184
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	1	4.5%	15	68.2%	6	27.3%	22
Total Clinical	Auto-Calculated	243	7.3%	2391	71.6%	706	21.1%	3340

Open Board

Report information

Report title: Workplace Race Equality Standard (WRES) Report 2026

Agenda item: -

Sponsor/Executive lead: Sarah Hodds, Interim Chief people officer

Report prepared by: Jamais Webbsmall-Eghan, Head of inclusion

Previously considered by: People and organisational development committee (Aug 2026), Workforce wellbeing and inclusion group (August 2026)

This report is for: ☒ Approval ☒ Assurance Discussion ☐ Information

This report supports the following ambitions within the organisational strategy:

- ☐ High quality care ☐ Joined up services
- ☒ Empowered to improve ☐ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What? *Summary of issue, including evaluation of the validity the data/information*

This statutory report provides an overview, analysis and recommendations based on 2025/2026 Workforce Race Equality Standard (WRES) data.

The data highlights the following areas as key priorities that must be addressed:

WRES indicator 1: (representation) *Low representation beyond band 7*

This indicator shows Global Majority staff are significantly over-represented at band 5 and significantly under-represented at band 7 and above.

WRES indicator 2: (shortlisting) *Significant and increasing inequity*

The relative likelihood of White applicants being appointed from shortlisting compared with Global Majority applicants has increased to 2.1, which is the highest level of inequity reported in the last four years.

WRES indicator 5: (bullying from the public) *Worsening experiences for Global Majority staff*

The percentage of Global Majority colleagues experiencing harassment, bullying or abuse from patients, relatives, or the public increased to 34.9%, the highest level reported in the last five years. The disparity between Global Majority and White staff remains significant and continues to widen.

WRES indicator 6: bullying from staff *Improvements made, but disparities persist*

Whilst there has been significant improvement over the last year which has seen a 7% reduction of reports from Global Majority staff, Global Majority staff remain more likely than White colleagues to experience bully, harassment and abuse from other staff.

WRES indicator 8: discrimination *Significant disparity in experience*

There continues to be a significant difference between Global Majority staff and White staff in relation to their experiences of discrimination from a manager or colleague. Although there has been a small improvement over the last year, the disparity between the Global Majority staff and White staff remains significant.

So what? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*

The data and analysis within this report are essential in helping the Trust understand and address racial inequities within the workforce. The findings provide evidence of where progress has been made and where further action is required to improve the experiences and outcomes of Global Majority staff.

This report supports the Trust in meeting its statutory obligations under the Workforce Race Equality Standard (WRES) and informs delivery of the Trust's strategic commitment to equality, diversity and inclusion. It also supports the Trust's ongoing commitment to anti-racism, including delivery of the UNISON Anti-Racism Charter, implementation of the NHS Staff Standards, and embedding the Trust's anti-racism principles across organisational culture, leadership, workforce practices and staff experience.

What next? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*

The report highlights key priority areas where focus must be placed to improve outcomes and experiences for Global Majority staff and to address the inequities identified within the data. In particular, the findings highlight recruitment and selection, career progression, representation within senior roles, and experiences of harassment, bullying, abuse and discrimination as areas requiring continued focus.

Actions to address these priority areas have already been embedded within the Trust's Workforce Inclusion Plan. Delivery of these actions will support the Trust's statutory commitments under the WRES, alongside its strategic commitment to creating and sustaining an inclusive and anti-racist culture. This includes progressing the Trust's commitments under the UNISON Anti-Racism Charter, NHS EDI Improvement Plan, NHS Tackling Racism Staff Standard, and the NHS Seven Anti-Racism Principles.

Progress will be monitored through a combination of WRES metrics, NHS Staff Survey results, workforce data, ethnicity pay gap analysis, staff network feedback, and regular reporting through Trust committees and groups. This will enable the Trust to assess the impact of this work, identify emerging issues, measure progress over time, and ensure appropriate oversight, accountability and continuous learning.

Action required by the Group:

- Review the data presented within the report. Ensure that it has been analysed fully and the narrative within this report is informative, clear, and accessible for all.
- Approve the report and provide permission for it to be published both internally and externally.

Governance and compliance

Risk and assurance:

The completion and publishing of report upholds the Trust's WRES and WDES statutory requirements. There is a requirement for this report to be published by 31 October 2026.

Equality, diversity and inclusion:

This report is centred on identifying and addressing areas of racial inequity experienced by Global Majority staff within the Trust. In addition to meeting the Trust's statutory responsibilities under the Workforce Race Equality Standard (WRES), the findings inform the Trust's wider commitment to equality, diversity and inclusion, anti-racism, and creating a fair and inclusive workplace for all.

The ongoing actions in place to address the findings of this report support delivery of the Trust's anti-racism commitments, including the UNISON Anti-Racism Charter, the NHS Tackling Racism Staff Standard, and the NHS 7 Anti-Racism Principles.

Sustainability:

Becoming and remaining an anti-racist organisation requires a sustained, long-term commitment. The work required to address racial inequity within the Trust is not intended to deliver short-term improvements alone, but to create meaningful, lasting and systemic change that dismantles the barriers and inequity faced by Global Majority staff and promotes race equity across all areas of the organisation.

Legal and regulatory context:

No implications are noted. Completion of this report meets the Trust's statutory requirements.

Workplace Race Equality Standard (WRES) report

2025/26

Contents

1. Context	6
2. Summary of key areas of work	7
Strengthening our anti-racism commitment through our policies	7
Establishing an Anti-Racist working group	7
Development and delivery of anti-racism training	8
Inclusive recruitment	8
Reviewing support for the Staff REACH network	9
Reviewing our Equality Impact Assessment (EIA) process	10
3. West Suffolk NHS Foundation Trust WRES 2024-25 key highlights	11
4. West Suffolk Foundation Trust WRES 2025-26: the overall picture	13
5. WSFT 2025 WRES analysis	16
WRES indicator 1: The percentage and number of staff by ethnicity	16
WRES indicator 2 - The relative likelihood of White applicants being appointed from shortlisting compared to Global Majority applicants	19
WRES indicator 3 - The relative likelihood of Global Majority staff entering the formal disciplinary process compared to white staff	20
WRES indicator 4 - The relative likelihood of White staff accessing non-mandatory training and CPD compared to Global Majority staff	21
4-Year Comparison of WRES indicators 1-4	22
WRES indicator 5 - Percentage of Global Majority staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	23
WRES indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24
WRES indicator 7 - Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion	25
WRES indicator 8 - Percentage of staff who experienced discrimination at work from their manager/team leader or other colleagues.	26
WRES indicator 9 - The representation of Global Majority people among board members	27
6. Conclusion and next steps	28
7. Appendices	30
Appendix A: number and percentage of non-clinical and clinical staff by ethnicity 2024/2025	30
Appendix B: number and percentage of non-clinical and clinical staff by ethnicity 2025/2026	31

1. Context

The NHS Workforce Race Equality Standard (WRES) is published annually and is an essential tool in supporting the NHS to be an inclusive and fair workplace. It helps evaluate progress and identify areas where further improvement is needed. This 2026 report is the latest version and uses data from March 2025 - March 2026.

The report utilises data from the electronic staff record (ESR) and the NHS Staff Survey to bring together a national picture of race across the NHS. NHS England's Equality, Diversity and Inclusion improvement plan, published in 2023 sets out six actions for systems to create an environment where staff feel they belong, can safely raise concerns, and are empowered to deliver the best care to our patients. As we work to make the NHS an inclusive and fair workplace, the WRES and Workforce Disability Equality Standard (WDES) remain essential tools for evaluating our progress and identifying areas where further improvement is needed. They provide a critical framework to ensure equality of opportunity is not just something we talk about but is central to our organisational culture, policies, and practices.

A note on language and terminology: West Suffolk NHS FT uses the term 'Global Majority' rather than BME or BAME.

The following page highlights a shortened summary of some of the key areas of work and achievements we have undertaken that are contributing towards a more equitable and inclusive organisation.

2. Summary of key areas of work

Strengthening our anti-racism commitment through our policies

During 2025/26, work commenced to strengthen and embed the Trust's anti-racism commitment within organisational policies and procedures.

This includes the development of a dedicated anti-racism section within the Trust's new *Creating an Inclusive Culture Policy*. The scope of the policy has been expanded so that it applies not only to employees, but also to patients, service users, visitors and anyone accessing Trust services, whether on a Trust site or within a community or home setting. In addition to the creation of a policy statement that clearly articulates the Trust's commitment to becoming and remaining an anti-racist organisation, the policy reinforces the Trust's zero-tolerance approach to all forms of racism, racial discrimination and racial prejudice including, but not limited to

- Anti-Black racism
- Anti-Asian racism
- Antisemitism
- Anti-Muslim hostility
- Gypsy, Roma and Traveller discrimination
- All other forms of racism and ethnic discrimination

More broadly, the policy reflects the Trust's strategic ambitions, particularly *Empowered to Improve* and *High-Quality Care*, and reinforces the behavioural expectations set out within the Trust's FIRST values.

The next phase of this work will focus on bringing these commitments to life through visible action, accountability and leadership, ensuring they are embedded within everyday practice and decision-making. The Trust's aim is to create and sustain an inclusive culture that benefits everyone, where all people are treated with dignity and respect, feel a sense of belonging, and understand their personal responsibility for upholding our values. This includes challenging racism and discrimination and promoting inclusion and anti-racism in their everyday interactions and behaviours.

Establishing an Anti-Racist working group

Work is underway to establish an Anti-Racist working group which will provide oversight, coordination and accountability for the Trust's anti-racism work.

This group will focus on supporting sustainable, visible and impactful progress towards race equity and ensuring anti-racism is embedded within organisational culture, decision-making and workforce practices.

Membership of the group will include key stakeholders from across the Trust who bring both lived and professional expertise. This will include colleagues with lived experience of racism and racial inequity, and colleagues and allies who are able to

influence and implement meaningful organisational change. Representation from local organisations with expertise in anti-racism and race equity will also be sought to provide additional insight, challenge and support.

Consideration is currently being given to how the group can create psychologically safe spaces for discussion, learning and constructive challenge whilst recognising the potential impact of engaging in anti-racism work, including vicarious and reactivated trauma. To support this, the Inclusion Team is working closely with colleagues within the Trust's Staff Psychology Service to ensure the group is designed in a way that promotes psychological safety, wellbeing and meaningful engagement for members, in addition to seeking advice and learning from other NHS organisations that have already established similar approaches.

The group will be established during 2026/27 and will coordinate and monitor progress against a range of commitments and priorities, including:

- Actions arising from the Workforce Race Equality Standard (WRES)
- NHS Equality, Diversity and Inclusion Improvement Plan actions
- Actions arising from ethnicity pay gap analysis
- Workforce race data and staff experience data
- Lord Mann's recommendations on combating racism in the NHS
- UNISON's Anti-Racism Charter
- NHS Tackling Racism Staff Standard
- NHS Seven Anti-Racism Principles

Through collective leadership, accountability and collaboration, the Anti-Racist working group will play a key role in translating the Trust's anti-racism commitments into measurable action, sustained progress and long-term cultural change.

Development and delivery of anti-racism training

Interactive, informative and powerful training sessions have been created and delivered to colleagues across the Trust, including students on their placements. In addition, facilitated anti-racism discussions and training sessions have also taken place within the People, Culture and Communications Directorate (January 2026), during a Trust Board development session in March 2026, and with the Trust's Senior leadership Team (March 2026).

Inclusive recruitment

Trust recruitment data continues to identify disparities in recruitment outcomes between White and Global Majority applicants, highlighting potential bias and inequity within the recruitment and selection processes, particularly at the shortlisting stage. We have taken the following steps to address these findings:

- Reviewing and strengthening the current recruitment and selection training to increase awareness and understanding of bias (and where it may occur)

within the recruitment and selection process), inclusive recruitment practices and decision-making

- Developing an inclusive recruitment toolkit to support recruiting managers and selection panel members
- Restricting access to TRAC, the Trust's recruitment system. Only staff who have completed the recruitment and selection training will have access to TRAC. Access is needed for anyone who is on a selection panel. Prior to this, there was only the requirement for the recruiting managers (the Chair of the panel) to have undertaken this training
- Reinforcing expectations that incidents of bias or discriminatory behaviour within the recruitment and selection process will be managed appropriately and may be addressed through formal conduct processes

Reviewing support for the Staff REACH network

The Trust's Staff REACH Network plays an integral role in providing peer support, insight, challenge and advocacy for Global Majority colleagues. However, maintaining momentum and consistent engagement has become increasingly challenging due to operational and clinical pressures.

This challenge is particularly significant for the REACH Network because a large proportion of Global Majority colleagues within the Trust work in clinical roles, where service demands can limit opportunities to participate in network activities. As a result, the network may experience barriers to engagement that are not experienced to the same extent by other staff networks.

To ensure the network remains sustainable, impactful and responsive to the needs of both its members and the wider organisation, the Inclusion Team will undertake a review of the network's remit, priorities and support arrangements during 2026/27. The review will focus on:

- exploring opportunities to strengthen alignment with the Trust's anti-racism work whilst preserving the network's important role in providing peer support, a sense of community and collective voice for Global Majority colleagues.
- Reviewing the governance arrangements of all staff networks alongside the support and resource available to them to ensure they are equipped to operate effectively and maximise their impact and visibility across the organisation

This review will help ensure that the REACH Network remains a valued source of support for colleagues whilst continuing to inform and influence the Trust's race equity and anti-racism priorities.

Reviewing our Equality Impact Assessment (EIA) process

Following the launch of the Trust's EIA process in January 2025, and the creation of the EIA PowerApp in September 2025 (which allows for EIAs to be reviewed, quality checked and submitted electronically), we will be reviewing the Trust's EIA process in 2026-2027 alongside other adjacent processes to ensure that it is integrated within Trust governance effectively and impactfully.

3. West Suffolk NHS Foundation Trust WRES 2024-25 key highlights

Performing well

WRES indicator 4 (training and CPD): Consistently equitable

For the fourth consecutive year, the relative likelihood remains at 1, indicating equitable access to non-mandatory training and CPD between White colleagues and Global Majority colleagues.

WRES indicator 3 (disciplinary processes): Maintaining an equitable position

Global Majority staff remain less likely than White staff to enter a formal disciplinary process. Whilst WRES seeks equity between staff groups, the data continues to indicate no evidence of disproportionate disciplinary action affecting Global Majority staff within the Trust.

Maintain focus - improvement required

WRES indicator 9 (board representation): Limited representation at Board level

Global Majority representation on the Board has remained unchanged over the last three years and continues to be significantly lower than the workforce ethnicity profile. Whilst turnover at Board level is relatively low, continued focus is required to improve representation over time.

WRES indicator 7: (career progression) Continuing disparity in progression outcomes

Despite equitable access to non-mandatory and CPD training for White and Global Majority staff (indicator 4), and only a small difference between the White and Global Majority staff regarding opportunities for career progression, workforce data continues to highlight a significant underrepresentation of Global Majority colleagues in Band 7 and above.

Work required- priority areas

WRES indicator 1: (representation) Low representation beyond band 7

This indicator shows Global Majority staff are significantly over-represented at band 5 and significantly under-represented at band 7 and above.

WRES indicator 2: (shortlisting) Significant and increasing inequity

The relative likelihood of White applicants being appointed from shortlisting compared with Global Majority applicants has increased to 2.1, which is the highest level of inequity reported in the last four years.

WRES indicator 5: (bullying from the public) *Worsening experiences for Global Majority staff*

The percentage of Global Majority colleagues experiencing harassment, bullying or abuse from patients, relatives, or the public increased to 34.9%, the highest level reported in the last five years. The disparity between Global Majority and White staff remains significant and continues to widen.

WRES indicator 6: bullying from staff *Improvements made, but disparities persist*

Whilst there has been significant improvement over the last year which has seen a 7% reduction of reports from Global Majority staff, Global Majority staff remain more likely than White colleagues to experience bullying, harassment and abuse from other staff.

WRES indicator 8: discrimination *Significant disparity in experience*

There continues to be a significant difference between Global Majority staff and White staff in relation to their experiences of discrimination from a manager or colleague. Although there has been a small improvement over the last year, the disparity between the Global Majority staff and White staff remains significant.

4. West Suffolk Foundation Trust WRES 2025-26: the overall picture

When considering our journey towards race equity, it is important to look at WRES over time. This gives a fuller picture of how things are changing and looks beyond year-on-year fluctuations that can be due to chance or short-term organisational changes. When a single metric goes up or down each year by a small amount, this is unlikely to indicate an improving/declining trend and instead suggests there has been no significant improvement/decline. The table below provides a transparent summary of our progress since initial reporting, which is explained in more detail throughout this report.

Table 1: A four-year overview, further information and work in progress for each WRES indicator

Area	4-year view	Further information
Indicator 1: Representation	Steady increase in the representation of Global Majority staff, but there continues to be underrepresentation in senior roles.	Whilst there is growing representation of Global Majority colleagues that remains higher than regional data, the over-representation of Global Majority colleagues at band 5 and the under-representation at band 7 and above indicates systemic barriers which must be addressed.
Indicator 2: Shortlisting	Increasing inequity	The relative likelihood of White applicants being appointed from shortlisting has increased from 1.67 in 2024/25 to 2.10 in 2025/26, representing the highest level of inequity reported during the last four years. Trust recruitment data also indicates disparities at the shortlisting stage, where White applicants are more likely to be shortlisted than Global Majority applicants.
Indicator 3: Disciplinary process	No evidence of disproportionate disciplinary outcomes for Global Majority staff	No Global Majority staff entered a formal disciplinary process during 2025/26, resulting in a relative likelihood score of 0. Whilst WRES seeks a position of equity represented by 1, Trust data continues to show no evidence of disproportionate disciplinary action affecting Global Majority colleagues. Due to the relatively small numbers involved, year-on-year changes should be interpreted with caution.

Indicator 4: Training	Consistently showing equity	The relative likelihood ratio has remained at 1 for four consecutive years, demonstrating sustained equity in access to non-mandatory training and CPD opportunities. However, this positive finding highlights that barriers to progression are likely to extend beyond access to training alone and may be influenced by wider organisational and systemic factors.
Indicator 5: Harassment, bullying and abuse from patients	Worsening experiences	The percentage of Global Majority colleagues experiencing harassment, bullying or abuse from patients, relatives, or the public has increased from 30.8% in 2021 to 34.9% in 2025, which is the highest level reported over the last four years. Whilst White staff have also experienced an increase, the disparity between staff groups remains significant and continues to exceed national benchmarking figures.
Indicator 6: Harassment, bullying and abuse from staff	Significant improvement over the last year	The percentage of Global Majority staff experiencing harassment, bullying or abuse from colleagues decreased by 7%, whilst reports from White staff decreased by 2.3%. This represents the lowest reported level in at least five years for both groups and it has significantly reduced the disparity of experience between White and Global Majority staff.
Indicator 7: Career progression	Persistent underrepresentation in senior roles despite relatively similar perceptions of career progression	2025/26 data shows little difference between White and Global Majority staff perceptions of equal opportunities for career progression or promotion (51.2% and 50.4% respectively). However, workforce data continues to demonstrate significant underrepresentation of Global Majority staff within senior leadership roles.
Indicator 8: Experiencing discrimination	Long-term disparity but with encouraging improvement during the last year	There has been a reduction in the percentage of both White and Global Majority staff experiencing discrimination at work from a manager, team leader or colleague during the last year. The largest improvement was seen

		amongst Global Majority staff, resulting in a reduction in the gap between White and Global Majority staff. Despite this positive progress, Global Majority staff continue to report substantially higher levels of discrimination than White colleagues (13.81% compared to 6.38%), indicating that a significant disparity in staff experience remains.
Indicator 9: Board representation	No increase in Global Majority representation on the Board since 2024	With two Global Majority colleagues on the Board, Global Majority representation remains the same as last year. Global Majority colleagues remain underrepresented on the Board compared to the overall workforce profile.

5. WSFT 2025 WRES analysis

WRES indicator 1: The percentage and number of staff by ethnicity

The WRES data indicates that as of 31 March 2025, the Trust had a workforce of 5338, a decrease from the previous year, which was 5507. There has been a 0.6% increase since 31 March 2025 in the percentage of staff who shared that they were from the Global Majority, bringing the percentage of Global Majority staff within the trust as at 31 March 2026 to 20.6%. The data also showed that 73.2 % of the workforce were White (-1.8% from March 2025), and 6.1% of colleagues had not shared their ethnicity data (+0.9% from March 2025).

This has been a positive trend over the past 3 years particularly when compared with the local ethnicity demographics of the West Suffolk population, which is around 92% White¹. Therefore, the Trust is reporting significantly higher proportionate figures of ethnicity in comparison to the overall regional data. Whilst this diversity is celebrated and welcomed, we must also acknowledge and address concerning data regarding the experiences of Global Majority staff. For example, the percentage of Global Majority staff within the Trust who have reported through the NHS Staff Survey that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, has increased each year and by a total of 4% between 2021 and 2025.

Table 1 shows the number and percentage of all staff by ethnicity over the past two years. Whilst there has been an increase of Global Majority staff, which is positive, there has also been an increase in the percentage of Global Majority staff in bands 6 and above. Whilst this is positive, there continues to be a stark and significant underrepresentation of Global Majority staff in senior roles (bands 7 and above) in relation to the percentage of Global Majority staff within the overall staff population.

The largest representation of Global Majority staff is at Band 5 (373/39.5%). Whilst this has decreased slightly since last year (395 / 41.1%), this number/percentage of Global Majority staff at this band remains almost double the equitable percentage of Global Majority staff when compared to the workforce demographics, which highlights a significant overrepresentation of Global Majority staff within this band. Conversely, Global Majority staff continue to be significantly underrepresented in bands 4 and bands 7 and above.

Although the 2025/26 figures show a decrease from last year in the percentage of Global Majority non-consultant career grade roles and trainee grade roles, the representation of Global Majority staff within these roles and within consultant roles continues to be much higher when compared to the overall percentage of Global

¹ [West Suffolk Demographics & Population Statistics 2025](#)

Majority staff within the Trust's workforce.

Table 2: number and percentage of all staff by ethnicity in 2024/25 and 2025/2026

Band	2024/25					2025/26				
	Global majority	White	Not disclosed	Total number of staff at each band	% Global majority at each band	Global majority	White	Not disclosed	Total number of staff at each band	% Global majority at each band
1	0	9	0	9	0%	0	0	0	0	0
2	78	398	19	495	15.8%	79	373	24	476	16.6%
3	126	822	35	983	12.8%	135	755	34	924	14.6%
4	25	538	19	582	4.3%	22	497	23	542	4.1%
5	395	508	59	962	41.1%	373	489	82	944	39.5%
6	150	692	46	888	16.9%	161	675	48	884	18.2%
7	50	557	34	641	7.8%	52	530	36	618	8.4%
8a	12	214	3	229	5.2%	15	214	3	232	6.5%
8b	6	65	4	75	8%	6	56	3	65	9.2%
8c	3	26	4	33	9%	4	30	4	38	10.5%
8d	0	13	0	13	0%	0	13	0	13	0%
9	0	9	0	9	0%	0	10	0	10	0%
VSM	0	4	0	4	0%	0	6	0	6	0%
Trainee Grade	67	78	25	170	39.4%	70	84	30	184	38%
Non-consultant career grade	90	22	27	139	64.7%	84	27	27	138	60.9%
Consultant	102	159	14	275	37.1%	101	151	12	264	38.3%
Total	1104	4114	289	5507	20.0%	1102	3910	326	5338	20.6%

NB: Appendixes A and B show the breakdown of clinical and non-clinical staff in 2024/25 and 2025/26, respectively.

WRES indicator 2 - The relative likelihood of White applicants being appointed from shortlisting compared to Global Majority applicants

Table 3: the number of shortlisted applicants by ethnicity, the number of appointed applicants from shortlisting by ethnicity, and the relative likelihood of White staff being appointed in comparison to Global Majority staff across the following three years: 2023/24, 2024/2025 and 2025/2026.

	2023/24			2024/25			2025/2026		
	White	Global Majority	Ethnicity Unknown	White	Global Majority	Ethnicity Unknown	White	Global Majority	Ethnicity Unknown
Number of shortlisted applicants	1288	1939	77	1023	1468	51	1255	1281	91
Number appointed from shortlisting	43	167	20	129	111	20	358	174	48
Relative likelihood of White staff being appointed in comparison to Global Majority staff	0.39			1.67			2.10		

The relative likelihood of White applicants appointed from shortlisting compared to Global Majority applicants has increased significantly over the last three years. It is currently 2.10, which is the largest figure it has been since 2022. A figure of 1 (with an acceptance range of between 0.8 and 1.2) would mean equitable appointment for White and Global Majority applicants from the shortlisting stage, so Trust data indicates that White applicants are significantly more likely to be appointed from the shortlisting stage in comparison to Global Majority colleagues.

Although this metric focusses on the relative likelihood of White staff being appointed in comparison to Global Majority staff, when exploring our recruitment and selection data further, it has also highlighted a disparity earlier on in the process, at the shortlisting stage. Trust data shows that White applicants are more likely to be shortlisted for the roles they apply for in comparison to Global Majority applicants.

WRES indicator 3 - The relative likelihood of Global Majority staff entering the formal disciplinary process compared to white staff

Table 4: the number of staff by ethnicity, the number of staff entering the formal disciplinary process by ethnicity, and the relative likelihood of Global Majority Staff entering the formal disciplinary process compared to White staff across the following three years: 2023/24, 2024/2025 and 2025/2026.

	2023/24			2024/25			2025/26		
	White	Global Majority	Ethnicity Unknown	White	Global Majority	Ethnicity Unknown	White	Global Majority	Ethnicity Unknown
Number of staff	4144	1010	325	4114	1103	285	3910	1102	326
Number of staff entering the formal disciplinary process	16	2	0	21	3	0	11	0	1
Relative likelihood of Global Majority Staff entering the formal disciplinary process compared to White staff	0.51			0.53			0.00		

The relative likelihood of Global Majority staff entering the formal disciplinary process compared to White staff is 0. This is a decrease since the previous year where the figure was 0.53. This figure of 0 indicates that Global Majority staff are less likely to enter the formal disciplinary process in comparison to White staff.

WRES indicator 4 - The relative likelihood of White staff accessing non-mandatory training and CPD compared to Global Majority staff

Table 5: the number of staff by ethnicity, the number of staff accessing non-mandatory training and CPD by ethnicity, and the relative likelihood of Global Majority Staff entering the formal disciplinary process compared to White staff across the following three years: 2023/24, 2024/2025 and 2025/2026

	2023/24			2024/25			2025/26		
	White	Global Majority	Ethnicity Unknown	White	Global Majority	Ethnicity Unknown	White	Global Majority	Ethnicity Unknown
Number of Staff	4144	1010	325	4114	1103	285	3910	1102	326
Number of staff accessing non-mandatory training and CPD	4144	1008	323	4114	1103	285	3902	1103	325
Relative likelihood of Global Majority staff accessing non mandatory training and CPD compared to White Staff	1			1			1		

Encouragingly, the ratio showing the relative likelihood of White staff remains at 1, which indicates equity. This means Global Majority staff are equally as likely to access non-mandatory training and CPD as White colleagues.

However, despite positive indication, progress, the results for indicator 1 on representation show that there is a significant overrepresentation of Global Majority colleagues at band 5 and underrepresentation of Global Majority staff in band 4 and in senior roles at Band 7 and above. This points to the need for deeper analysis to better understand the types of training and CPD that different staff groups are accessing, particularly whether leadership development and experiential learning opportunities, which are often key to career progression, are being taken up equally. Whilst we remain committed to ensuring that access to training opportunities is equal

for all staff, it is important that our equity and inclusion efforts do not default to a 'deficit model' (NHS England, 2019)². This approach assumes that disparities in representation are the result of weaknesses among Global Majority staff that can simply be addressed through targeted training and development programmes. Instead, we must recognise the deep rooted and systemic issues that exist in society and are reflected within our organisation, and we must be proactive and intentional in addressing these. To create lasting and meaningful change, and to support the career progression of Global Majority colleagues, we need to focus on transforming our culture, systems, and processes to remove structural barriers, tackle racial bias, and ensure equitable opportunities.

4-Year Comparison of WRES indicators 1-4

Table 6 below is a 4-year comparison of indicators 1-4 which shows a steady increase in Global Majority staff from 2022-2026. Indicator 2 would suggest a position that has worsened significantly over the last two years, as it now shows the highest disparity between the likelihood of White applicants being appointed from shortlisting and Global Majority applicants in a four-year period, highlighting and reiterating that improving recruitment and selective processes within the Trust remains a key priority for the Trust.

Indicator 3 shows a decrease from the previous two years and movement away from the figure of 1, which highlights equity. This means that Global Majority staff are less likely to enter the formal disciplinary process. Lastly, indicator 4 highlights continual and consistent best practice in relation to equitable access to non-mandatory training and CPD between White staff and Global Majority.

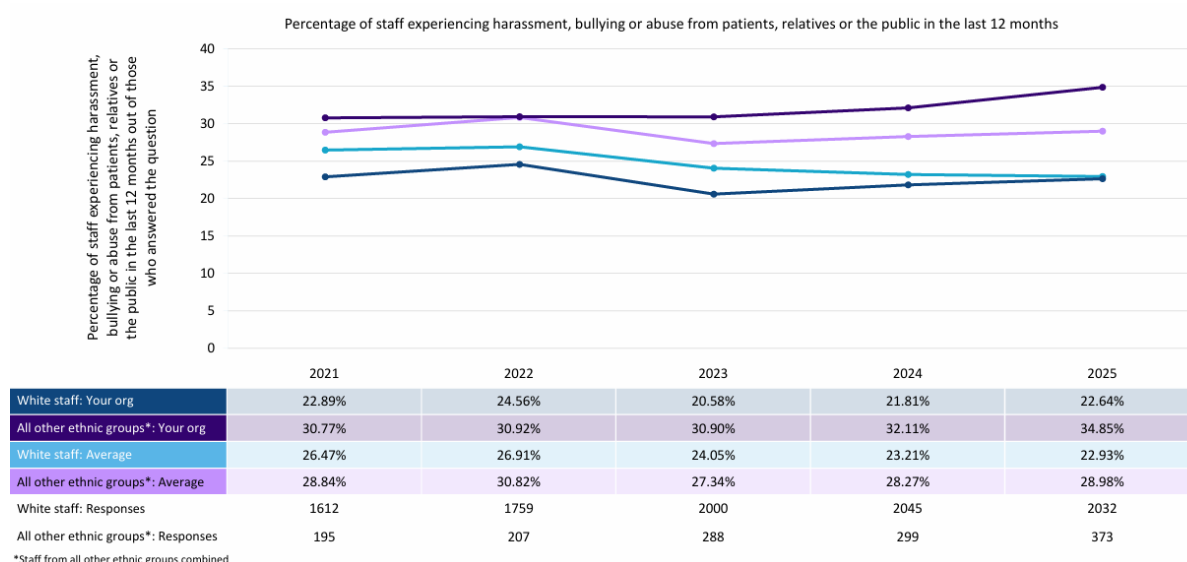
² NHS England (2019) A model employer: Increasing black and minority ethnic representation at senior levels across the NHS [PDF] <https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf>

Table 6: a four-year comparison of WRES indicators 1-4

		2022/23	2023/24	2024/25	2025/26
Indicator 1	No. of staff at the Trust	5214	5479	5502	5338
	Number (percentage) of Global Majority staff at the Trust	890 (17.1%)	1010 (18.4%)	1103 (20.1%)	1102 (20.6%)
Indicator 2	Relative likelihood of white staff appointed from shortlisting compared to Global Majority staff	1.22	0.39	1.67	2.10
Indicator 3	Relative likelihood of Global Majority staff entering formal disciplinary process compared to white staff	0	0.51	0.53	0
Indicator 4	Relative likelihood of white staff accessing non-mandatory training & CPD compared to Global Majority staff	1	1	1	1

The data for Indicators 5-8 have been sourced from the National NHS Staff Survey which provides a comparison of the outcomes of the response for White and Global Majority staff. (Source: [Local results for every organisation | NHS Staff Survey](#))

WRES indicator 5 - Percentage of Global Majority staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months



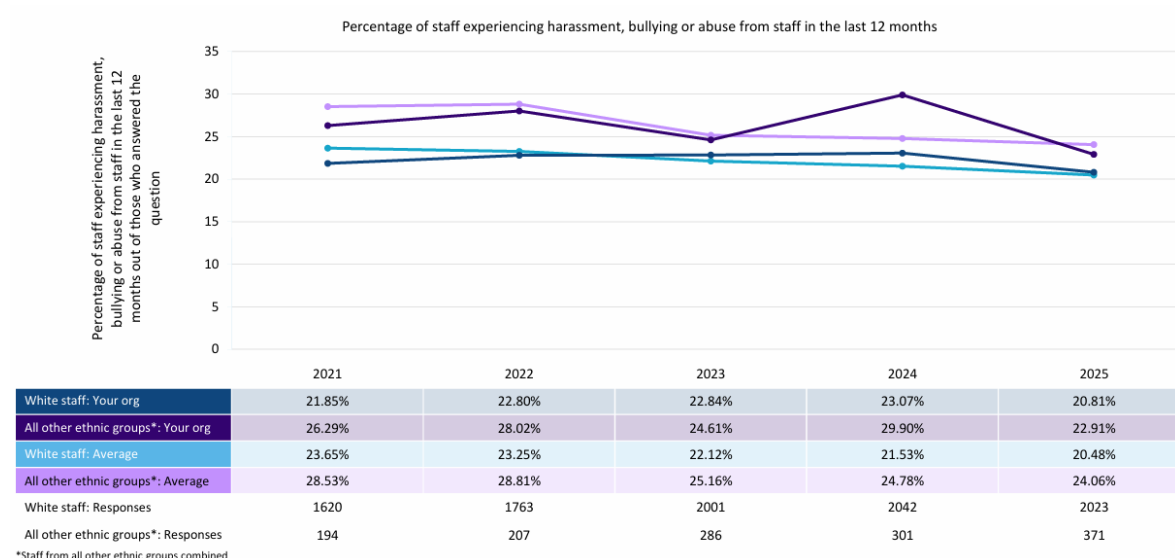
Over the last five years, Trust data consistently shows a higher proportion of Global Majority staff who responded to the survey have experienced harassment, bullying or abuse from patients, relatives, or the public. Current data shows that 34.9% of Global Majority respondents have experienced this, which is the highest percentage in the last five years. During this time frame, Trust figures for Global Majority staff

who have experienced this behaviour have been between 1-6% higher than the national average when compared to similar sized acute and community Trusts.

For White staff, there has been an 0.83% increase in the percentage of staff survey respondents who had experienced harassment, bullying or abuse from patients, relatives or the public. This is the second year that there has been an increase, as prior to this there had been a notable decrease between 2022 and 2023.

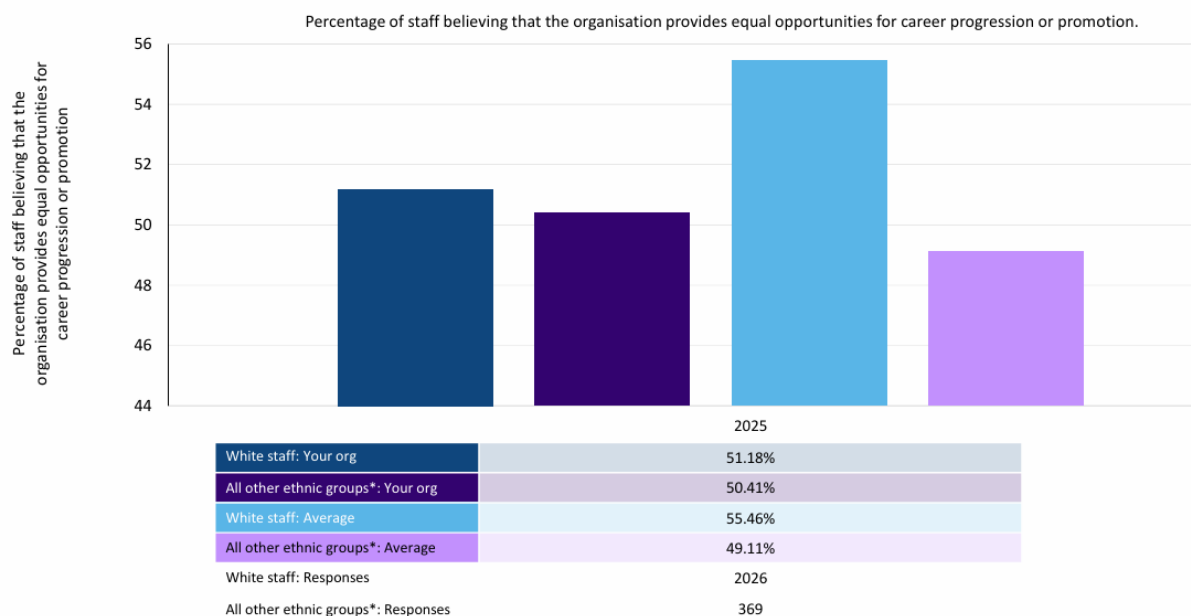
Additionally, over the last five years, Trust figures for White staff have been between 1-4% lower than the national average when compared to similar sized acute and community Trusts.

WRES indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



This has been an area of significant progress for the Trust over the last year. Our recent data shows a significant decrease (-7%) in the percentage of Global Majority staff who responded to the survey who had experienced harassment, bullying or abuse from other staff over the last year. There has also been a decrease of -2.3% of White staff who responded to the survey who had experienced harassment, bullying or abuse from other staff over the last year. This marks the lowest percentage in at least the last five years for both Global Majority and White staff and reduces the percentage difference between the two staff groups in respect of their experiences of harassment, bullying and abuse from other members of staff (from 6.8% in 2024 to 2.1% in 2025).

WRES indicator 7 - Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion



*Staff from all other ethnic groups combined.

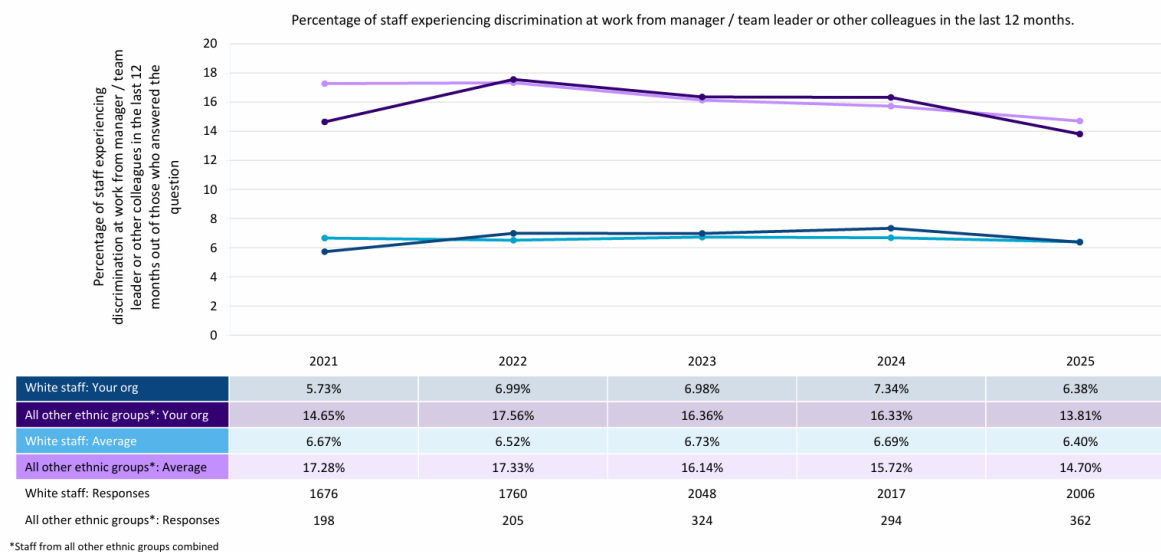
Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported. For more information, please refer to the *Technical Guide*: <https://www.nhsstaffsurveys.com/survey-documents/>

Trust data shows that the 51.2% of White staff and 50.4% of Global Majority staff survey respondents feel that the Trust provides equal opportunities for career progression or promotion. Our Trust data here is slightly above the national average for Global Majority staff (+1.3%) and below average for White staff (-4.28%).

It should be noted that, due to changes in the wording of this question during the 2025 staff survey, previous year's results are not reported as they are not comparable.

When considering this data alongside our representation data (indicator 1), it becomes clear that career progression must be a priority area in our wider inclusion and workforce strategies. Focused and tailored interventions are required to identify and address the specific barriers faced by Global Majority colleagues. As our data from indicator 4 already indicates sustained equity in terms of access to non-mandatory training and CPD, we must ensure that there is fair and equitable access other types of formal and informal development opportunities, such as participation in leadership and management programmes, and mentoring and networking, which are important for career development.

WRES indicator 8 - Percentage of staff who experienced discrimination at work from their manager/team leader or other colleagues.



There has been a slight decrease (-1%) in the percentage of White staff experiencing discrimination at work from a manager, team leader or other colleague from the previous year. The percentage from the current year is the lowest it has been since 2022.

There was a larger decrease in the percentage of Global Majority staff experiencing discrimination at work from a manager, team leader or other colleague from the previous year (-2.5%). There continues to be a significant difference between the experiences of discrimination from a manager or colleague for Global Majority staff and White staff.

WRES indicator 9 - The representation of Global Majority people among board members

Table 7: Number of voting and non-voting board members by ethnicity as at 31st March of each year between 2023 and 2026.

		2023	2024	2025	2026
Executive Board	White	7	6	6	7
	Global Majority	0	0	0	0
	Ethnicity Unknown	0	0	1	0
Non-Executive	White	8	5	8	5
	Global Majority	2	2	2	2
	Ethnicity Unknown	0	0	0	0
Total		17	13	17	14

		2023	2024	2025	2026
Voting	White	14	11	14	12
	Global Majority	1	2	2	2
	Ethnicity Unknown	0	0	1	0
Non-Voting	White	1	0	0	0
	Global Majority	1	0	0	0
	Ethnicity Unknown	0	0	0	0
Total		17	13	17	14

The Global Majority representation of all board members is not reflective of the workforce demographic and this has been consistent within the reporting of WRES data over the past 4 years. Whilst turnover in this staff group tends to be low, there must be continuous proactivity within the Trust to attract a more diverse pool of candidates when appointing new board members, particularly when non-executive directors have reached the end of their tenure at the Trust.

6. Conclusion and next steps

This report demonstrates areas of positive progress in relation to race equity, particularly the continued increase in the representation of Global Majority staff within the workforce, equitable access to non-mandatory training and CPD, and improvements in the experiences of harassment, bullying and abuse from colleagues and experiences of discrimination at work. However, significant disparities remain between the experiences and outcomes of White and Global Majority staff, particularly in relation to recruitment, progression, representation within senior roles, harassment, bullying, abuse and discrimination.

The Trust's approach to advancing race equity and embedding anti-racism within our organisational culture and practices is not limited to the annual WRES reporting process. Key priorities are embedded within the *Empowered to Improve* ambition of the Trust's 2025-2028 Strategic Plan and supported through delivery of the Trust's Workforce Inclusion Plan and anti-racism commitments.

The progress of this important work is monitored through a combination of WRES metrics, NHS Staff Survey results, workforce data, ethnicity pay gap reporting, staff feedback and regular reporting through Trust committees and groups, ensuring ongoing oversight and accountability. This work is further supported by the Trust's commitment to the UNISON Anti-Racism Charter, the NHS Tackling Racism Staff Standard and the NHS Seven Anti-Racism Principles.

It must be recognised that becoming and remaining an anti-racist organisation is a long-term commitment. While improvements are expected over time, some of the disparities identified within this report reflect wider societal, systemic and institutional inequities that will take several years to address fully. The focus during 2026/27 will therefore be on sustaining progress, embedding anti-racist practices and ensuring improvement activity is targeted towards the areas of greatest need. Success will be measured through trends over time rather than year-on-year fluctuations alone.

The following areas have been identified as priorities for 2026/27. Actions to progress these areas are embedded within the Trust's workforce inclusion plan:

- Strengthening leadership, accountability and coordination of all anti-racism activity through the establishment of the Anti-Racist working group.
- Continuing to take steps to improve the representation and progression of Global Majority staff within senior leadership roles
- Reducing inequity within recruitment, specifically within the shortlisting and appointment stages
- Improving career progression, development opportunities and talent pipelines for Global Majority staff
- Reducing experiences of racism, harassment, bullying, abuse and discrimination

- Embedding anti-racism across organisational culture, leadership, governance, policies and workforce practices
- Improving the experiences of Global Majority staff by strengthening inclusion, belonging and psychological safety

7. Appendices

Appendix A: number and percentage of non-clinical and clinical staff by ethnicity 2024/2025

	Measure	# Global Majority	% Global Majority	# White	% White	# Unknown/Null	% Unknown/Null	Total
1a) Non Clinical Staff								
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	0	0.0%	9	100.0%	0	0.0%	9
Bands 2	Headcount	54	14.3%	311	82.5%	12	3.2%	377
Bands 3	Headcount	15	4.9%	286	92.9%	7	2.3%	308
Bands 4	Headcount	17	4.7%	333	92.5%	10	2.8%	360
Bands 5	Headcount	7	4.5%	145	92.4%	5	3.2%	157
Bands 6	Headcount	5	5.6%	82	92.1%	2	2.2%	89
Bands 7	Headcount	7	7.1%	87	88.8%	4	4.1%	98
Bands 8a	Headcount	7	7.9%	81	91.0%	1	1.1%	89
Bands 8b	Headcount	5	11.9%	34	81.0%	3	7.1%	42
Bands 8c	Headcount	3	15.0%	15	75.0%	2	10.0%	20
Bands 8d	Headcount	0	0.0%	11	100.0%	0	0.0%	11
Bands 9	Headcount	0	0.0%	7	100.0%	0	0.0%	7
VSM	Headcount	0	0.0%	4	100.0%	0	0.0%	4
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	86	8.2%	939	89.1%	29	2.8%	1054
Cluster 2: AfC bands 5 to 7	Auto-Calculated	19	5.5%	314	91.3%	11	3.2%	344
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	12	9.2%	115	87.8%	4	3.1%	131
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	3	7.1%	37	88.1%	2	4.8%	42
Total Non-Clinical	Auto-Calculated	120	7.6%	1405	89.4%	46	2.9%	1571
1b) Clinical Staff								
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	24	20.34%	87	73.73%	7	5.93%	118
Bands 3	Headcount	111	16.44%	536	79.41%	28	4.15%	675
Bands 4	Headcount	8	3.60%	205	92.34%	9	4.05%	222
Bands 5	Headcount	388	48.20%	363	45.09%	54	6.71%	805
Bands 6	Headcount	145	18.15%	610	76.35%	44	5.51%	799
Bands 7	Headcount	43	7.92%	470	86.56%	30	5.52%	543
Bands 8a	Headcount	5	3.57%	133	95.00%	2	1.43%	140
Bands 8b	Headcount	1	3.03%	31	93.94%	1	3.03%	33
Bands 8c	Headcount	0	0.00%	11	84.62%	2	15.38%	13
Bands 8d	Headcount	0	0.00%	2	100.00%	0	0.00%	2
Bands 9	Headcount	0	0.00%	2	100.00%	0	0.00%	2
VSM	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	143	14.1%	828	81.6%	44	4.3%	1015
Cluster 2: AfC bands 5 to 7	Auto-Calculated	576	26.8%	1443	67.2%	128	6.0%	2147
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	6	3.5%	164	94.8%	3	1.7%	173
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	15	88.2%	2	11.8%	17
Total Clinical	Auto-Calculated	725	21.6%	2450	73.1%	177	5.3%	3352
Medical & Dental Staff, Consultants	Headcount	102	37.09%	159	57.82%	14	5.09%	275
of which Senior Medical Managers	Headcount	0		0		0		0
Medical & Dental Staff, Non-Consultants career	Headcount	90	64.75%	22	15.83%	27	19.42%	139
Medical & Dental Staff, Medical and dental trainee	Headcount	67	39.41%	78	45.88%	25	14.71%	170
Medical & Dental Staff, Other	Headcount	0		0		0		0
Total Medical and Dental	Auto-Calculated	259	44.35%	259	44.35%	66	11.30%	584
Number of staff in workforce	Auto-Calculated	1104	20.05%	4114	74.70%	289	5.25%	5507

Appendix B: number and percentage of non-clinical and clinical staff by ethnicity 2025/2026

	Measure	# Global Majority	% Global Majority	# White	% White	# Unknown/Null	% Unknown/Null	Total
1a) Non Clinical Staff								
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 2	Headcount	53	15.2%	284	81.4%	12	3.4%	349
Bands 3	Headcount	13	5.3%	228	92.3%	6	2.4%	247
Bands 4	Headcount	17	5.1%	306	92.4%	8	2.4%	331
Bands 5	Headcount	8	5.3%	138	90.8%	6	3.9%	152
Bands 6	Headcount	5	6.0%	77	91.7%	2	2.4%	84
Bands 7	Headcount	10	11.0%	77	84.6%	4	4.4%	91
Bands 8a	Headcount	5	6.4%	71	91.0%	2	2.6%	78
Bands 8b	Headcount	5	14.3%	28	80.0%	2	5.7%	35
Bands 8c	Headcount	3	13.6%	17	77.3%	2	9.1%	22
Bands 8d	Headcount	0	0.0%	11	100.0%	0	0.0%	11
Bands 9	Headcount	0	0.0%	8	100.0%	0	0.0%	8
VSM	Headcount	0	0.0%	5	100.0%	0	0.0%	5
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	83	9.0%	818	88.2%	26	2.8%	927
Cluster 2: AfC bands 5 to 7	Auto-Calculated	23	7.0%	292	89.3%	12	3.7%	327
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	10	8.8%	99	87.6%	4	3.5%	113
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	3	6.5%	41	89.1%	2	4.3%	46
Total Non-Clinical	Auto-Calculated	119	8.4%	1250	88.5%	44	3.1%	1413
1b) Clinical Staff								
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	26	20.47%	89	70.08%	12	9.45%	127
Bands 3	Headcount	122	18.02%	527	77.84%	28	4.14%	677
Bands 4	Headcount	5	2.37%	191	90.52%	15	7.11%	211
Bands 5	Headcount	365	46.09%	351	44.32%	76	9.60%	792
Bands 6	Headcount	156	19.50%	598	74.75%	46	5.75%	800
Bands 7	Headcount	42	7.97%	453	85.96%	32	6.07%	527
Bands 8a	Headcount	10	6.49%	143	92.86%	1	0.65%	154
Bands 8b	Headcount	1	3.33%	28	93.33%	1	3.33%	30
Bands 8c	Headcount	1	6.25%	13	81.25%	2	12.50%	16
Bands 8d	Headcount	0	0.00%	2	100.00%	0	0.00%	2
Bands 9	Headcount	0	0.00%	2	100.00%	0	0.00%	2
VSM	Headcount	0	0.00%	1	100.00%	0	0.00%	1
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	153	15.1%	807	79.5%	55	5.4%	1015
Cluster 2: AfC bands 5 to 7	Auto-Calculated	563	26.6%	1402	66.2%	154	7.3%	2119
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	11	6.0%	171	92.9%	2	1.1%	184
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	1	4.8%	18	85.7%	2	9.5%	21
Total Clinical	Auto-Calculated	728	21.8%	2398	71.8%	213	6.4%	3339
Medical & Dental Staff, Consultants	Headcount	101	38.26%	151	57.20%	12	4.55%	264
of which Senior Medical Managers	Headcount	0	0.00%	1	100.00%	0	0.00%	1
Medical & Dental Staff, Non-Consultants career grade	Headcount	84	60.87%	27	19.57%	27	19.57%	138
Medical & Dental Staff, Medical and dental trainee grades	Headcount	70	38.04%	84	45.65%	30	16.30%	184
Medical & Dental Staff, Other	Headcount	0		0		0		0
Total Medical and Dental	Auto-Calculated	255	43.52%	262	44.71%	69	11.77%	586
Number of staff in workforce	Auto-Calculated	1102	20.64%	3910	73.25%	326	6.11%	5338

4.2. Putting You First Awards - Anna Hollis (ATTACHED)

To Assure

Putting You First awards

July – September 2026 winners

Trust Board 25 September 2026

Compassionate care,
healthier communities

Putting You First (PYF) awards

PYF awards celebrate colleagues throughout the Trust for modelling Trust values in their daily working life and inspiring patients and/or colleagues with their approach.

Nominations can be made by any member of WSFT staff at any time in the year. All nominations are collated by the communications team and the list of nominees is reviewed by members of the executive group.

The winners are selected and notified, as well as being offered the opportunity for the chief executive to present the award and hear any feedback from Board members. The citations are included in the following Trust Board report.

Sponsors of unsuccessful nominees are signposted to our Radar 'Star' scheme as an alternative way of celebrating and recognising their colleague(s).

Fairness

We value fairness and treat each other appropriately and justly.

Inclusivity

We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.

Respect

We respect and are kind to one another and to patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.

Safety

We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.

Teamwork

We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local healthcare system.

Compassionate care,
healthier communities

Anastasia Flowitt, Assistant Practitioner, Early Intervention Team

Nominated by Oluwatosin Adeyemi, EIT

Whilst reviewing a patient in AAU, Anastasia was asked to assist with a patient living with dementia who was refusing blood tests. The situation had escalated to the point where the RPI team had been contacted and were already involved, with five staff members gathered at the bedside preparing to restrain the patient in order to obtain the blood sample.

Before restraint was used, Anastasia took the initiative to engage with the patient. She spent time building rapport, talking to her about her favourite TV programme and calmly explaining why the blood tests were needed to check for a possible infection.

Although the patient was confused and expressed mistrust of staff, Anastasia remained patient, compassionate, and reassuring throughout. Her calm and person-centred approach successfully de-escalated the situation. The patient became settled enough for the blood sample to be taken without the need for restraint.

Instead of requiring multiple staff members to physically hold her, only three staff were involved: Anastasia supported one hand to prevent interference during the procedure, another staff member supported the arm being used for venepuncture, and the nurse was able to obtain the blood sample successfully. As a result, what could have been a distressing and potentially traumatic experience for the patient was managed safely, respectfully, and with dignity.

Anastasia's actions prevented the need for restraint, reduced the number of staff required, and ensured the patient was treated with compassion and respect despite her cognitive impairment. This was an excellent example of person-centred care in practice and demonstrates Anastasia's exceptional communication skills, empathy, initiative, and commitment to preserving the dignity of some of our most vulnerable patients.

Compassionate care,
healthier communities

Samantha Pearce (Health records Admin), Lily Swales (Outpatients) *Nominated by Samantha Lumley, deputy manager, health records admin*

Samantha was receptioning the late clinic in Main outpatients when a patient came to her and asked where the exit was. The patient was very confused and Samantha noticed the patient still had a wrist I.D on, she asked the patient which ward he came from, but the patient became very agitated and kept swing his walking stick at her and the nurse that came to help.

Samantha saw the NHS number and managed to jot it down, Samantha asked the nurse to stay with the patient so she could look up the patient on the system. The nurse didn't want to stay with the patient because he was becoming violent. Samantha had to leave the patient to find out which ward he was on and the patient was on F7.

Once Samantha had got back to the patient he was walking down the stairs of the Hospital. Samantha didn't know what to do as she didn't want to leave this vulnerable patient. So she called a nursing colleague whose telephone number she had. Lily Swales, a nursing assistant, had finished her shift and was walking home, but after hearing Samantha's telephone call came running back to help. Security couldn't help as the patient was off site.

Samantha came back to the Hospital and two nurses from F7 were on their way to help. Lily stayed with the patient and called the police. Both Samantha and Lily showed excellent patient care and demonstrated all the trust values even though the patient was becoming very agitated and angry. They never left the patient and they both demonstrated true care and compassion.

Compassionate care,
healthier communities

Russell Williams, senior endpoint engineer

Nominated by Abbey Hurrell, administrator

I had an ongoing IT issue that nobody in either our trust or Addenbrookes had been able to resolve since I started my role back in April. Russell very kindly took this on, liaising with the IT department in Addenbrookes directly, in order to prevent me feeling like the 'middle man'.

He showed such determination & tenacity & simply would not give up until the issue was resolved. My team & I are extremely grateful as I am now able to do my job properly!

Radiography/CT team (23 people nominated)

Nominated by Anna-Marie Langford, senior radiographer

What a team - as always focusing on detail and putting patients first. Today at the CDC an intricate pathology involving a Type A aortic dissection with pericardial effusion, suspected haemorrhagic was spotted on the Ct chest scan.

This was escalated to the radiologist Stephen Scullion who promptly reported and discussed with ED EPIC - we called the ambulance and the patient was blue lighted to Papworth.

This was a brilliant spot and highlights the importance of reviewing images at point of scan - which all of the CT team do daily! Well done team!

Compassionate care,
healthier communities

4.3. Freedom to Speak Up Guardian (Jane Sharland) (ATTACHED)

To inform

WSFT Open Board Meeting

Report information

Report title: Freedom to Speak Up Quarters 1 and 2, 2026-27

Agenda item:

Sponsor/Executive lead: Chief People Officer

Report prepared by: Jane Sharland, Freedom to Speak Up Guardian

Previously considered by:

This report is for: ☐ Approval ☒ Assurance ☒ Discussion ☒ information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☐ Joined up services
- ☒ Empowered to improve ☐ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

What? The attached report summarises the data regarding concerns raised to the Freedom to Speak Up Guardian in Quarters 1 and 2, 2026 - 2027, with comparison to previous quarters, and highlight's themes identified from concerns raised. This report unusually covers two quarters in order that the data and themes may be considered by the Board in a timely manner.

The report contains:

- Information on national changes to Freedom to Speak Up (FTSU) arrangements
- Data sent to NHS England
- Anonymous reporting – percentages and themes
- Who is speaking up – by professional group
- Themes identified, and learning and actions
- Feedback on the FTSU experience
- Ongoing work to promote a speaking up culture within the organisation.

So what? The report ensures Board oversight of numbers and themes of concerns being raised via the FTSU service. It also assures the Board of ongoing work to promote and support a speaking up culture across the organisation, and assurance that the service meets the national requirements.

What next? Actions in response to themes are included in section 4.

Action required by the board: The Trust Board is invited to note the themes identified and actions that have been taken.

Governance and compliance

Risk and assurance: This work aims to support staff to speak up about any concerns in a psychologically safe way, and for those concerns to be heard by the Board and acted on appropriately

Equality, diversity and inclusion: All work toward promoting FTSU aims to be fully inclusive. A full Equality Impact Assessment (EIA) was completed in relation to the FTSU policy review. This can be found [here](#)

Sustainability: n/a

Legal and regulatory context: The current NHS England standard contract (5.10) requires all Trusts to appoint a Freedom to Speak Up Guardian and comply with the requirements of NHS England.

Guardian's Report Q1 and Q2, 2026-2027. April-June, and July-Sept 2026

1. Introduction

1.1 All NHS Trusts in England are mandated to have FTSU Guardians appointed as a part of the NHS contract. Their role is to help embed an open and learning-based Trust culture by ensuring policies and procedures are in place to support staff to speak up, raise concerns or share feedback on matters that can adversely affect the care that is delivered or the wellbeing or experience of staff.

2. News from the National Guardians Office (NGO) and NHS England

2.1 The NGO closed at the end of June 2026 and NHS England has taken over some of the activities previously undertaken by the NGO. Trusts are now expected to take on greater responsibility and accountability for embedding effective FTSU arrangements.

NHS England has published revised FTSU responsibilities for NHS Trusts: [NHS England » The future of Freedom to Speak Up](#)

2.2 Data for Quarter 1, 26-27 has been submitted to the NHS England portal for the first time. The FTSU Guardian, the NED for FTSU and the Trust's chief information officer have discussed and agreed that it is appropriate that the Guardian should continue to submit FTSU data to the new reporting system.

2.3 Data for Quarter 2 will be submitted when the portal opens in early October.

3. Data and analysis

3.1 Number of concerns

The number of concerns raised with the Guardian in Quarter 1 was 56 and for Quarter 2 is 45 (as of 16/9/26).

The number of concerns raised to the FTSU Guardian has remained relatively stable overall, with quarterly totals generally ranging between 40 and 55 concerns. While there was a notable spike in Q2 2024/25 and a further period of increased activity during Q2-Q3 2025/26, these were not sustained and reporting levels subsequently returned to the established range. Overall, the data indicates a normal variation around a relatively stable baseline. Higher numbers are not necessarily negative, as they may indicate increased confidence in speaking up and awareness of routes to do so.

3.2 Anonymous reporting

Whilst it is important to have an option for anonymous reporting, there are challenges in investigating anonymous cases due to limited information and the difficulty in providing feedback or support for those raising the concern.

An anonymous reporting option is available via the Raising Concerns page of the Trust Intranet, or by letter to the Guardian at the Education Centre. In Quarters 1 and 2, there were five (9%) and 11 (25%) respectively.

The percentage of concerns raised anonymously is an indicator for how confident staff feel to speak up. The national average for anonymous reporting across the NHS is 12.2%.

The proportion of concerns raised anonymously had shown a clear overall decline over the last five years, where most quarters recorded fewer than 10% of concerns being raised anonymously, (with a one off peak of 40% in Q3, 24-25). This may indicate increasing confidence amongst staff in speaking up openly and trust in the processes for handling concerns. However, there has been a moderate increase in this quarter which will be monitored to see if it represents a normal fluctuation or a new trend.

3.3 Themes of anonymous reporting

These anonymous reports are taken seriously, and each one was investigated as far as possible. Some of the anonymous reports this quarter were very generalised, not mentioning any detail of department or individuals, making them impossible to investigate further. The Guardian would like to propose additional narrative to the anonymous reporting form to highlight this issue, but without discouraging anyone to speak up:

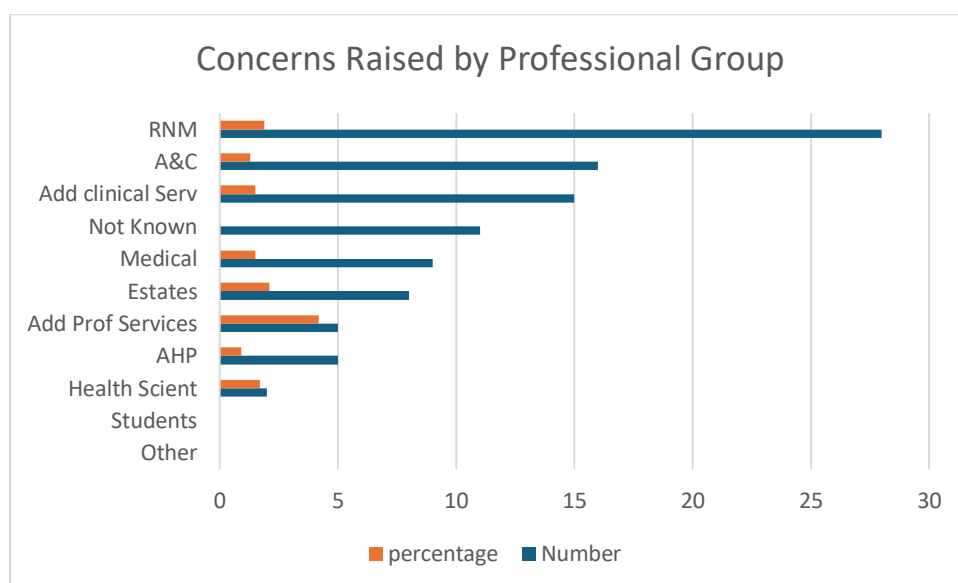
We understand that there may be times when you wish to remain anonymous. If you choose to do so, please try to include as much relevant information as possible, such as what happened, where/what department, when it happened, and who was involved. This helps

ensure that your concern can be properly understood and, where appropriate, investigated. Without enough detail, our ability to look into the matter may be limited.

The subjects of the anonymous reports were incivility between staff members, poor team culture/low psychological safety in a particular team, unused/wasted equipment, car parking policy, management of colleague disability, low staffing levels, communication and timeline re administration transformation, inappropriate behaviour of a staff member to a patient.

The Guardian, working with the Trust's Speak Up champions, continues to tackle barriers to speaking up (see Principles of FTSU below) and to assure staff that detriment to those who do speak up will not be tolerated in the Trust.

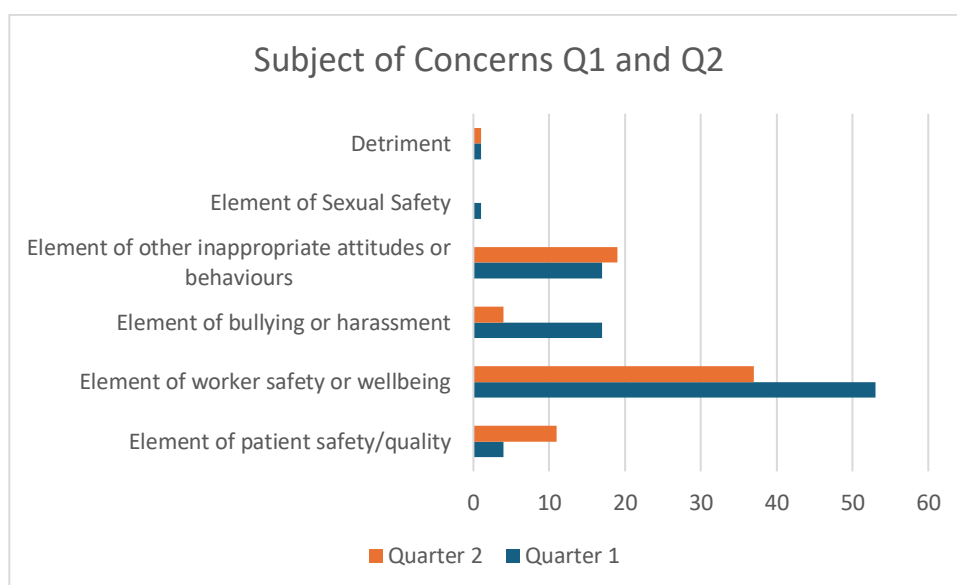
3.4 Who is speaking up?



The greatest number of reports were from nursing and midwifery staff, as expected due to this being the largest staff group. As a percentage of workforce, the highest was from additional professional, scientific and technical staff. This may just be an anomaly as there were 5 concerns raised by this group but as a percentage this is highest. However, this is worth monitoring for trends.

3.5 What were people speaking up about?

A large majority of cases involve an element of staff safety or wellbeing. Patient safety concerns comprised 7% of concerns raised in Quarter 1 and 25% so far in Quarter 2, the national figure is 18%. These concerns included concerns re a particular surgical procedure, clinical competencies, consultant cover on one ward, infection prevention and control (IPC), clinical judgement in a particular case, staffing levels on two wards, administration/appointment systems, health and safety risk from vaping. Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place where most patient safety concerns are reported.



4. Themes from Q1 and Q2 2026/27 with learning and actions

4.1 Every Freedom to Speak Up concern is dealt with on an individual basis and raised with the appropriate senior leader. Feedback is given to individuals raising concerns on action taken. However, the Trust continues to address broad themes raised via FTSU, and accepts the information gained as a gift to support future learning and development to help support improvements across the organisation.

4.2 Sexual safety concerns: One incidence concerning sexual safety was reported to the FTSU Guardian in Quarter 1, none in Quarter 2. As part of the ongoing work of the Sexual Safety Working Group, to ensure compliance with the Sexual Safety Charter, [Sexual safety - West Suffolk NHS Intranet](#) (principle 10) all cases of a sexual nature will be collated with those raised through other routes. Clear pathway for triangulation is currently being developed to ensure no cases are missed or recording duplicated.

4.3 Themes:

Theme	Issues	Learning and Action
Attitudes and behaviour	Incivility, between staff members, difficulties in relationships between staff members	Importance of maintaining a professional communication style. HR/management discussions with staff involved. Staff encouraged to review the values and Behaviours Framework. Behaviour Framework - Behaviour framework
	Bullying	17 concerns were raised in Q2, 30% of cases raised contained an element of bullying. This is a considerable increase on recent figures, although a high proportion of

		these related to the same individual (14). The number reduced to four in Quarter 2, 9%. No cases of bullying are acceptable, and we remain vigilant as the staff survey tells us cases are often not reported for fear of reprisals. The cases were investigated and addressed and support offered to those speaking up.
Policies, Processes and Procedures	Car parking - technical issues with new system, disagreement with permissions to park on site.	Parking team have resolved all inappropriate fines. Decision has been taken to delay annual price increases until April 2027, as a gesture to staff following parking disruption. Staff referred to policy, concerns raised to ADO estates and facilities.
	Secondments, recruitment and selection	Concerns re ending of secondments, and slotting in to post. Investigation showed full interview process as per R&S policy had been followed. Importance of communicating effectively about the nature of any contract, and transparency regarding recruitment into posts.
	Sickness management	Concerns around being called to stage 1 attendance meetings has been a theme. Importance of communicating the positive purpose of these meetings to staff is a learning point.
Service Changes and Consultations	Impact of redesign communication	Concerns raised about the extended timeline and transparency of communication and information regarding the administration transformation. Importance of understanding the impact of these changes on staff members, especially those directly affected, and communicating as effectively as possible. Further comms to be delivered and updating of the dedicated information hub on the intranet.
Staff Wellbeing	Racism, by two members of staff in a department, raised by a colleague	Robust investigation and addressed by senior management. Re-iteration to that team of Trust's zero tolerance of racism and bespoke inclusion and active bystander training to team. We know from NHS staff survey that sadly racism exists in within the NHS, and there is more work to be done, but feel encouraged that colleagues in our Trust are willing to call it out.
	High stress levels due to high	Issue raised to senior management for support. Importance of taking all abuse

	patient acuity, and abuse from patients.	seriously and recognising impact on staff, whether patient has capacity or not. Acknowledgement, reassurance and support from senior nurse management and HR.
	Staff development – frustrations when unable to complete competencies in timely way, or be released for training	Leaders made aware of staff concerns. Importance of development and training for job satisfaction and feeling valued. Support given to staff to access training.
Environment	Hot weather - air con, ventilation, water dispenser, uniform policy/dress code	Importance of comfortable working environment. Repairs expedited to air con unit and water dispenser unit supplied. Uniform dispensation for staff during very hot weather, application of existing dress code.
	Exterior lighting – poorly lit paths	Re-lamping underway. Active recruitment for more electricians.

5. Feedback on FTSU process

5.1 Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. The themes emerging from the FTSU process evaluation indicated once again that it was a positive experience being able to talk to an independent and impartial person.

- Five responses were received to the FTSU feedback survey for Quarters 1 and 2. All respondents said they would speak up again.
- A new question has been added to the feedback survey for Quarter 2 and going forward. 'Do you feel the Guardian acted independently and impartially in both principle and practice when dealing with your concerns'. All respondents answered yes.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

A regular freedom to speak up session to provide encouragement to speak up would be helpful.

Thank you, I feel better for being heard.

I felt very safe and supported.

The Guardian I spoke to was so warm and welcoming I would do it again if needed.

6. Work to improve and develop a speaking up culture

6.1 The Guardian and FTSU champions are working to improve the culture of speaking up throughout WSFT. Our actions reflect the eight key areas aligned with the National Guardian's Office guidance for leaders and managers. These can be read in full [here](#).

6.2 Complete actions from **Reflection and Planning Tool**. See [here](#)

6.3 **FTSU Policy Review**. A clearly defined policy owned by all is central to the effectiveness of the Freedom to Speak Up service. Policy Review was approved by Policy Working Group in May 2026. The accompanying Policy EIA has been approved by EDI lead in April 2026.

Next steps: Undertake survey in autumn 2026 to assess awareness and accessibility of policy and service.

6.4 The first principle of creating a speaking up culture is **valuing speaking up**, especially by senior leaders. In addition to ongoing support by execs for champion training, the CPO and CEO have attended a twilight shift alongside the guardian to ensure visibility of highest-level support for speaking up, to all staff, including those who face barriers to engagement with speaking up and other support, such as night workers.

6.5 **Communications**. The FTSU Guardian continues to work closely with the communications team to plan and deliver regular Trust-wide communications, to share key learning and encourage engagement with FTSU across the organisation.

6.6 **Awareness raising and training**. FTSU sessions are regularly delivered as part of staff inductions, including the Welcome for Trust-wide new starters, resident doctors, registered nurses and preceptorship programmes. FTSU also delivers sessions in quality improvement training for leaders and managers and bespoke to many teams. These sessions raise awareness of the FTSU service and reinforce the organisation's commitment to an open, speaking-up culture, and ensuring new colleagues know how to raise concerns and feel safe to do so. The Speak Up and Listen Up on-line training is mandated and currently have compliance levels of 90% and 85% respectively (August 2026).

COMFORT BREAK (10 mins)

5. RESPONSIBLE WITH RESOURCES

5.1. Finance and Performance Committee - Committee's Key Issues (ATTACHED)

To Assure

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Finance and Performance			Date of meeting: 19 August 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
7.1	Operational performance The Committee took assurance on performance above trajectory in relation to Cancer, Diagnostics and Urgent Community response. The Committee recognised continued risks relating to UEC performance and virtual ward occupancy and Elective Care. UEC is meeting the 4-hour plan but 12 hour waits and ambulance handover are still behind plan	3 Partial	A Continuous Quality Improvement (CQI) project has been set up to address UEC performance and flow taking a Trust-wide approach. An initial workshop and learning from others suggests incremental shifts can make a big difference to overall outcomes.	The refurbished theatres reopened in July. The UEC CQI project will continue. The elective recovery plan is discussed below	Alert	1 No escalation
7.2	Elective Recovery Plan Update The Committee looked at activity information for Month 4 and Finance performance for Month 3. Current performance shows elective inpatient activity remains significantly below the income	3 Partial	There are some positive indicators including improved outpatient performance, increasing theatre activity, strong benchmarking for Patient Initiated Follow-Up (PIFU)	This remains an area of risk. Recovery plans are in place across all divisions, focused particularly on General Surgery, Orthopaedics and Gynaecology.	Escalate	2. Escalate to MEG

Originating Committee: Finance and Performance			Date of meeting: 19 August 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
	target plan at 26.3% below expected levels, while outpatient and day case activity are closer to plan. Overall elective income is £1.87m below plan at Month 3.		remote appointments and Do Not Attends (DNAs). But there remains a risk that planned elective and financial recovery trajectories will not be achieved.			
7.3	Productivity Deep Dive The Committee undertook a deep dive into clinical productivity across outpatient services and theatres. The Committee took some assurance that there was comprehensive governance systems and improvement programmes in place. But theatre productivity has been significantly impacted by estates issues and refurbishment projects, losing 338 theatre days between January 2024 and July 2026.	2 Partial	Whilst some specialties demonstrate improving utilisation, variation remains across services, creating operational and financial risks if planned productivity improvements are not sustained.	There are number of projects in place to improve productivity and to manage the operational and financial risks associated with those improvement plans.	Alert	1 No Escalation

Originating Committee: Finance and Performance			Date of meeting: 19 August 2026			
Chaired by: Antoinette Jackson			Lead Executive Directors: Nicola Cottington and Jonathan Rowell			
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity of the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Alert, Inform, Assure, Escalate, Approve	Escalation for action: 1. No escalation, reporting for information 2. To other assurance committee / SLT 3. Escalate to Board
9.1 and 9.2	Finance Month 3 report and CIP Update The reported deficit for July 2026 is £319k, being £127k worse than plan (£1.0m YTD). This is largely due to clinical income being behind plan. The recurring deficit position continues to be just below £1.5m without the monthly deficit funding (of almost £1.1m per month). The Trust has identified £21.3m/£20.4m of unweighted/weighted CIP opportunities respectively against a full year target of £29.7m leaving a gap of £8.4m/£9.3m unweighted / weighted CIP. It is positive to note that 94% of those schemes identified, deliver recurrent savings.	3.Partial	The Trust is forecasting to break even in 2026/27 after receiving agreed deficit support funding. However, there are risks to this position in relation to delivering our CIP Plan; in particular (as discussed above) recovering our elective activity plan and achieving significant productivity improvements.	A range of additional CIP opportunities are being explored. CIP risks are being reviewed through programme boards and oversight groups.	Alert	1 No escalation

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence...	Further consideration...
 What? Deepening understanding of the evidence and ensuring its validity	Validity – the degree to which the evidence... • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
 So what? Increasing appreciation of the value (importance and impact) – what this means for us	Value – the degree to which the evidence... • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
 What next? Exploring what should be done next (or not), informing future tactic / strategy, agreeing follow-up and future evidence of impact		• Recommendations for action • What impact are we intending to have, by when and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

Definitions

Alert	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require further action/decision.	Inform	No action required. Reporting to update on discussion within a reporting committee's TOR.
Escalate	Formally raise an issue, concern, or risk to a higher level of authority so that it can be reviewed and acted upon appropriately	Assure	Information to demonstrate that appropriate action is being taken within a reporting committees' TOR.
Approve	A request by the reporting committee that something meets required standards but needs higher authority permission to proceed/sign off before being implemented.		

5.2. Finance Report (ATTACHED)

To Review

Presented by Jonathan Rowell

Meeting/committee title: Public Board Meeting

Report information

Report title: Finance Report – as at 31 August 2026 (M5)

Agenda item:

Sponsor/Executive lead: Jonathan Rowell (Chief Finance Officer)

Report prepared by: Nick Macdonald (Director of Operational Finance)

Previously considered by: N/A

This report is for: ☒ Approval ☒ Assurance ☒ Discussion ☒ information

This report supports the following ambitions within the organisational strategy:

- ☐ High quality care ☐ Joined up services
- ☐ Empowered to improve ☒ Responsible with resources
- ☐ Fit for tomorrow

Executive summary

The attached Finance Board Report details the financial position for Month 5 of 2026/27 (August 2026).

Summary

We have agreed a deficit plan of £12.8m in 2026/27 which will be funded with deficit support funding.

The reported surplus for August 2026 is £223k, being £283k better than plan (£717k worse than plan YTD). This is largely due to a non recurring VAT refund of £385k. Income has improved now that the refurbished theatres are fully operational and we anticipate that the shortfall on income in Q1 will continue to be recovered.

Underlying Position and Forecast

Our recurring deficit position is around £1.3m without the monthly deficit funding (of almost £1.1m per month).

Since we are now earning much of our income on an activity basis it is more difficult to ascertain our overall deficit run rate due to some of our costs being fixed and some variable in line with activity (and income) levels. This can be further complicated by timing differences between when costs are incurred and when income is recognised (eg temporary pay claims, consumable stock usage and coding delays). In August we have seen an increase in income and an associated increase in pay and non-pay costs.

The Trust is forecasting to break even in 2026/27 after receiving the agreed deficit support funding. However, there are risks to this position in relation to recovering our activity plan and delivering our CIP programme.

Action required by the board: The Committee is asked to review and approve this report.

Governance and compliance

Add explainer for each of the below.

Risk and assurance: Financial risk.

Equality, diversity and inclusion: N/A

Sustainability: Financial sustainability.

Legal and regulatory context: Financial reporting.

WSFT Monthly Finance Report

2026-27– August 2026
for Public Board
25th September 2026



Putting you first

Executive Summary

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The Trust is forecasting to break even in 2026/27 after receiving the agreed deficit support funding. However, there are risks to this position in relation to recovering our activity plan and delivering our CIP programme.

Workforce

Since April 2024, we have reduced our overall staffing levels by 294 WTEs (5.7%), including a number of additional posts that have been externally funded.

Cash

The cash balance as at 31 August 2026 remains healthy at £25.9m and includes £2.7m of capital cash that has not yet been spent. The strong position in March is continuing into the new financial year. Cash continues to be rigorously monitored to ensure that the Trust remains on plan and does not fall below the £1.1m enforced by NHS England.

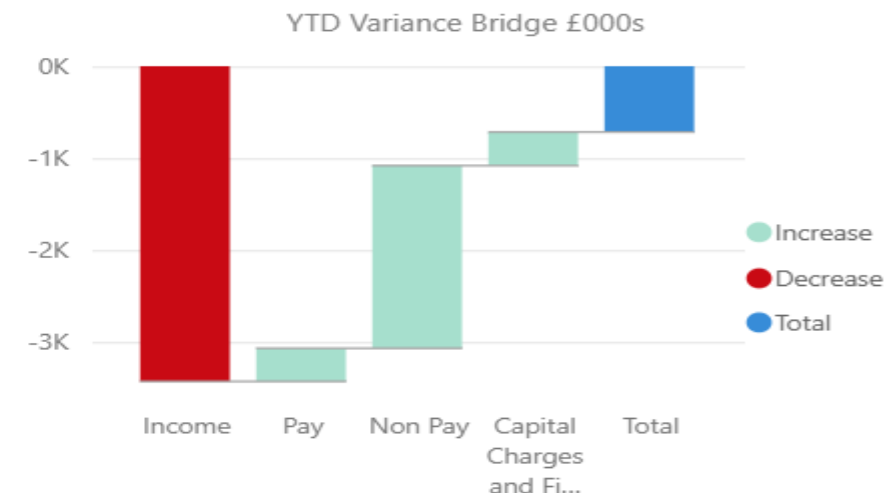
Capital

The Capital Plan for 2026/27 was agreed at £47m. During the first quarter of 2026/27, RAAC funding was also approved of £1.24m and some of the return to constitutional standards (RtCS) bids were rejected, taking the plan to £40.9m for the year. At month 5 (year to date) the Trust has spent £6.5m against a year to date plan of £18.6m. The plan included year to date spend on the RtCS projects, the funding for which has only just been formally approved. There has also been a delay in some projects meaning that the original phasing of the plan is not accurate. The Trust is still forecasting to achieve the plan set for 2026/27.

26/27 M5 position

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
Income									
Clinical Income	35.4	35.4	0.0	178.0	174.4	-3.6	428.6	428.6	0.0
Non Clinical Income	2.4	2.4	0.1	11.9	12.2	0.3	28.4	28.4	0.0
Total	37.8	37.9	0.1	189.9	186.6	-3.3	457.0	457.0	0.0
Pay									
Substantive	-25.0	-23.9	1.2	-125.8	-118.8	7.0	-300.2	-300.2	0.0
Bank	-0.5	-1.8	-1.4	-2.6	-8.7	-6.1	-6.0	-6.0	0.0
Agency	0.0	-0.1	-0.1	0.0	-0.5	-0.5	0.0	0.0	0.0
Total	-25.5	-25.8	-0.3	-128.3	-128.0	0.4	-306.2	-306.2	0.0
Non Pay									
Clinical Non Pay	-6.3	-6.6	-0.3	-32.7	-32.7	0.0	-77.5	-77.5	0.0
Non Clinical Non Pay	-3.1	-3.3	-0.3	-15.7	-17.9	-2.3	-37.8	-37.8	0.0
Total	-9.3	-9.9	-0.6	-48.4	-50.7	-2.3	-115.2	-115.2	0.0
Capital Charges	-2.0	-1.9	0.1	-10.0	-9.8	0.1	-23.9	-23.9	0.0
Reserves	-1.0	0.0	1.0	-4.3	0.0	4.3	-11.9	-11.9	0.0
Total	-0.1	0.2	0.3	-1.1	-1.8	-0.7	-0.3	-0.3	0.0

Deficit YTD £	1.8M	
Variance against plan YTD £	-0.7M	Adverse
Movement in month against plan £	0.3M	Favourable
EBITDA Position YTD £	7.8M	Favourable
EBITDA margin YTD	4%	Favourable
Cash at bank	£25.9M	

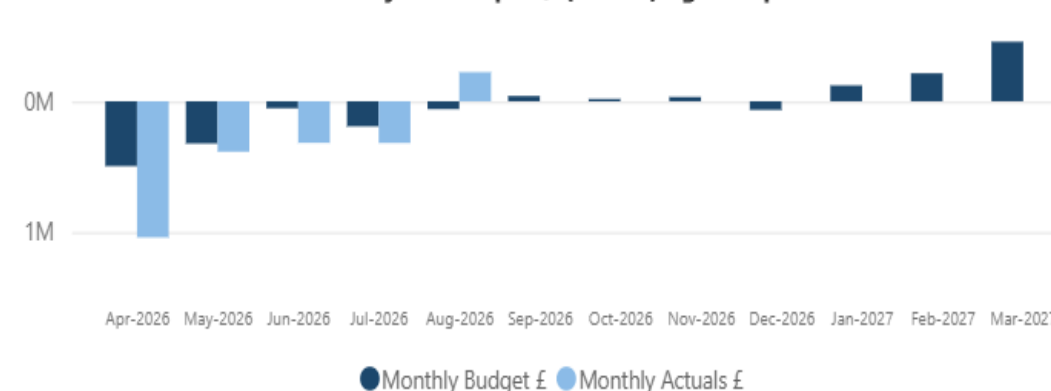


Income and Expenditure Summary – August 2026

A favourable variance of £283k was reported in August, largely relating to non-recurring credits

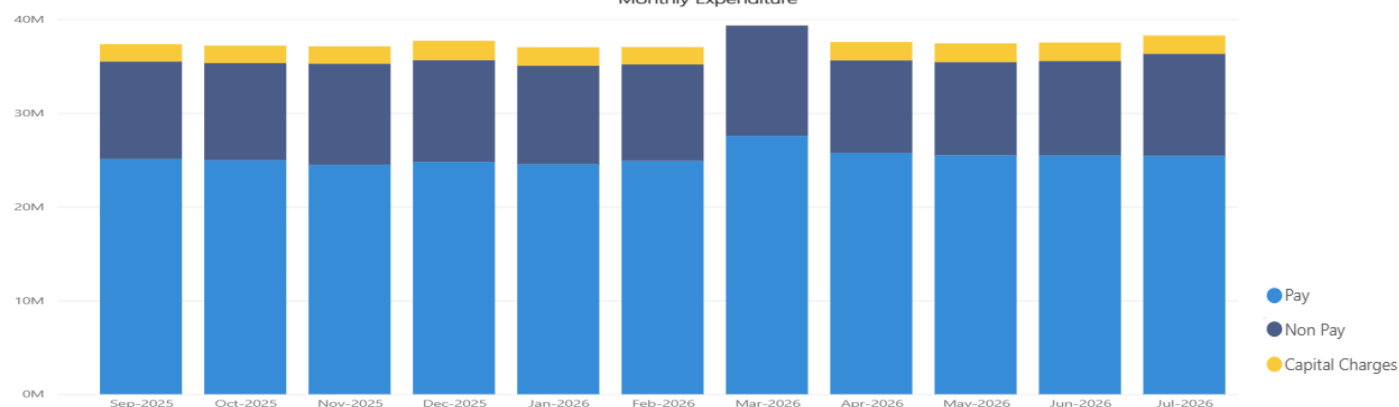
Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
▲				Adverse variance > 1% ↓ Adverse variance within 1% → On plan or favourable variance ↑
In month surplus/ (deficit)	-60	223	283	↑
YTD surplus/ (deficit)	-1,125	-1,842	-717	↓
Clinical Income YTD	178,016	174,434	-3,582	↓
Non-Clinical Income YTD	11,880	12,179	299	↑
Pay YTD	128,336	127,975	361	↑
Non-Pay YTD	48,390	50,656	-2,266	↓
EBITDA YTD	8,906	7,823	-1,083	↓
EBITDA %	4.7	4.2	-0.5	↓

Monthly I&E surplus/ (deficit) against plan

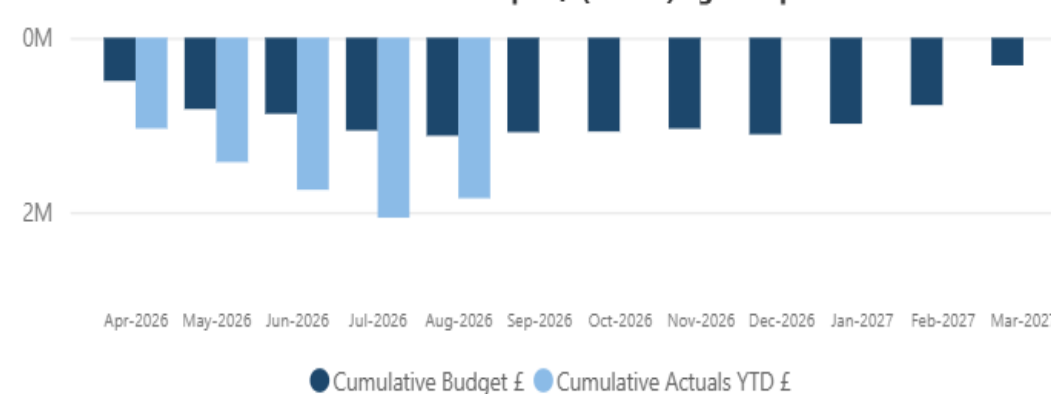


The chart below shows the monthly expenditure over a rolling 12 months (including the impacts of pay awards and inflation). Note that March includes the impact of impairments and centrally funded pension contributions

Monthly Expenditure



Cumulative I&E surplus/ (deficit) against plan



Divisional Financial Performance M5 26/27

In the August position we have reported YTD variances against planned clinical income within each Division. This aligns with the expenditure savings associated with lower than planned activity levels which are reflected in the Divisions expenditure positions.

Division	In-Month Budget £000s	In-Month Actuals £000s	In-Month Variance £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s
Medical Services	8,330	8,907	-577	42,041	44,482	-2,440
Income	-458	-219	-239	-2,318	-1,508	-810
Pay	6,569	6,836	-267	32,971	33,760	-789
Non Pay	2,173	2,245	-72	11,158	12,003	-844
Capital Charges	46	44	1	230	227	3
Surgical Services	6,186	5,984	202	31,133	31,288	-154
Income	-410	-794	385	-2,048	-1,275	-772
Pay	5,261	5,166	95	26,288	25,401	887
Non Pay	1,317	1,602	-285	6,794	7,087	-292
Capital Charges	18	11	6	98	75	23
Women & Children Services	2,393	2,734	-341	11,891	13,387	-1,497
Income	-244	85	-329	-1,220	31	-1,251
Pay	2,439	2,524	-85	12,144	12,678	-534
Non Pay	198	125	73	964	678	286
Capital Charges	0	0	0	2	0	2
Clinical Support	3,939	3,922	17	19,584	20,125	-541
Income	-717	-658	-58	-3,583	-3,347	-237
Pay	3,234	3,196	38	16,046	16,235	-189
Non Pay	1,422	1,385	37	7,118	7,236	-118
Capital Charges	0	0	0	3	0	3
Community Services	5,245	5,106	139	26,410	25,575	836
Income	-643	-726	84	-3,161	-3,292	130
Pay	4,258	4,076	182	21,124	20,351	772
Non Pay	1,580	1,706	-126	8,201	8,267	-66
Capital Charges	50	50	0	247	248	-1
Facilities	1,671	1,690	-19	8,545	8,253	292
Income	-471	-471	0	-2,333	-2,441	109
Pay	1,264	1,211	53	6,343	6,107	236
Non Pay	879	950	-72	4,535	4,588	-53
Capital Charges	8E-5	0	8E-5	0	0	0
Contract Income & Corporate	-27,704	-28,566	862	-138,479	-141,267	2,788
Income	-34,856	-35,097	241	-175,234	-174,781	-453
Pay	2,472	2,802	-330	13,421	13,443	-22
Non Pay	1,769	1,891	-122	9,619	10,798	-1,178
Capital Charges	1,883	1,838	45	9,384	9,274	110
Reserves	1,028	0	1,028	4,331	0	4,331
Deficit/(Surplus)	60	-223	283	1,125	1,842	-717

Pay Costs by Staff Type August 2026

The increase in pay related costs during August relate largely to the increased costs of additional activity, which has generated increased income.

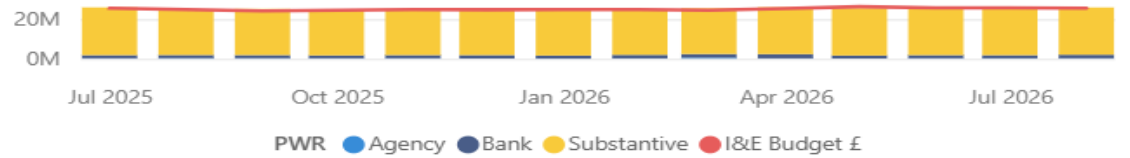
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	6,266	6,132	6,788	656	30,487	33,703	3,216
	Nursing	8,665	8,636	9,525	889	43,332	47,413	4,081
	Sci & Professional	1,271	1,260	1,428	168	6,267	7,105	838
	A&C	3,544	3,553	3,892	339	17,709	19,493	1,784
	AHP	2,613	2,610	2,780	169	12,988	13,977	989
	Prof & Tech	280	278	283	5	1,405	1,414	10
	Support Staff	895	908	962	54	4,529	4,785	256
	Other	208	484	-33	-517	2,067	-150	-2,217
	Unallocated central funding	-11	-11	-609	-598	-21	-1,989	-1,968
	Total	23,732	23,850	25,016	1,165	118,762	125,751	6,989
Additional Medical Sessions	Medical Staff	236	366	155	-211	1,568	929	-639
	Total	236	366	155	-211	1,568	929	-639
Bank & Locum Staff	Medical Staff	475	567	145	-423	2,519	759	-1,760
	Nursing	572	601	16	-585	3,016	75	-2,941
	Sci & Professional	17	23	2	-21	70	17	-53
	A&C	58	59	1	-58	302	11	-290
	AHP	16	16	4	-12	82	4	-78
	Prof & Tech	1	0	1	0	4	3	0
	Support Staff	168	156	137	-19	862	687	-175
	Other	0	0	0	0	1	0	-1
	Total	1,307	1,422	306	-1,116	6,856	1,556	-5,299
Agency	Medical Staff	92	116	0	-116	431	0	-431
	Sci & Professional	0	-2	0	2	-2	0	2
	A&C	0	0	0	0	2	0	-2
	Prof & Tech	15	15	0	-15	87	0	-87
	Total	107	130	0	-130	518	0	-518
Overtime	Nursing	18	26	0	-26	97	5	-92
	Sci & Professional	6	5	0	-5	36	0	-36
	A&C	5	2	8	5	32	38	6
	AHP	20	4	0	-4	46	0	-46
	Prof & Tech	14	5	11	7	62	57	-5
	Total	64	42	19	-23	272	100	-172
Total		25,445	25,811	25,496	-315	127,975	128,336	361

Pay Costs (by Staff Group) August 2026

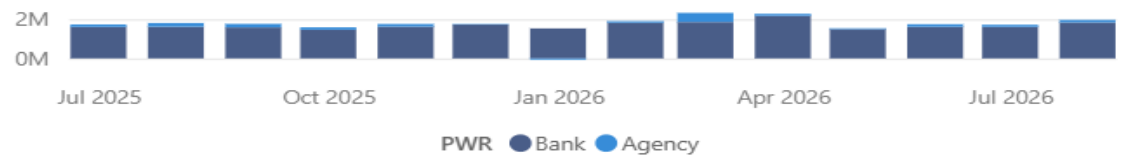
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	6,266	6,132	6,788	656	30,487	33,703	3,216
	Additional Medical Sessions	236	366	155	-211	1,568	929	-639
	Bank & Locum Staff	475	567	145	-423	2,519	759	-1,760
	Agency	92	116	0	-116	431	0	-431
	Total	7,069	7,182	7,089	-94	35,005	35,391	386
Nursing	Substantive	8,665	8,636	9,525	889	43,332	47,413	4,081
	Bank & Locum Staff	572	601	16	-585	3,016	75	-2,941
	Overtime	18	26	0	-26	97	5	-92
	Total	9,254	9,262	9,541	278	46,446	47,493	1,047
Sci & Professional	Substantive	1,271	1,260	1,428	168	6,267	7,105	838
	Bank & Locum Staff	17	23	2	-21	70	17	-53
	Agency	0	-2	0	2	-2	0	2
	Overtime	6	5	0	-5	36	0	-36
	Total	1,293	1,286	1,429	144	6,370	7,122	752
A&C	Substantive	3,544	3,553	3,892	339	17,709	19,493	1,784
	Bank & Locum Staff	58	59	1	-58	302	11	-290
	Agency	0	0	0	0	2	0	-2
	Overtime	5	2	8	5	32	38	6
	Total	3,608	3,614	3,901	287	18,044	19,542	1,498
AHP	Substantive	2,613	2,610	2,780	169	12,988	13,977	989
	Bank & Locum Staff	16	16	4	-12	82	4	-78
	Overtime	20	4	0	-4	46	0	-46
	Total	2,649	2,631	2,784	153	13,116	13,981	865
Prof & Tech	Substantive	280	278	283	5	1,405	1,414	10
	Bank & Locum Staff	1	0	1	0	4	3	0
	Agency	15	15	0	-15	87	0	-87
	Overtime	14	5	11	7	62	57	-5
	Total	310	298	295	-3	1,557	1,474	-83
Support Staff	Substantive	895	908	962	54	4,529	4,785	256
	Bank & Locum Staff	168	156	137	-19	862	687	-175
	Total	1,063	1,065	1,100	35	5,391	5,472	81
Other	Substantive	208	484	-33	-517	2,067	-150	-2,217
	Total	208	484	-33	-517	2,067	-150	-2,217
Other	Bank & Locum Staff	0	0	0	0	1	0	-1
	Total	0	0	0	0	1	0	-1
Unallocated central funding	Substantive	-11	-11	-609	-598	-21	-1,989	-1,968
	Total	-11	-11	-609	-598	-21	-1,989	-1,968
Total		25,445	25,811	25,496	-315	127,975	128,336	361

Pay Costs (trends)

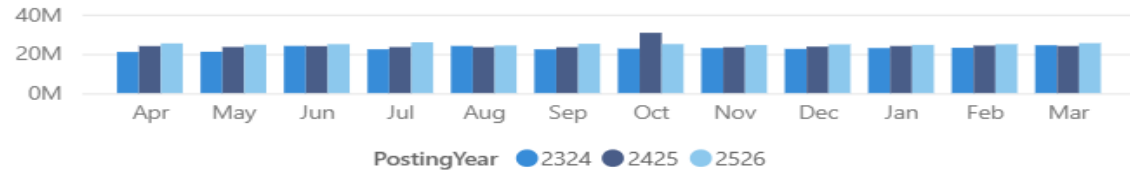
Rolling 14 month pay expenditure (bar) v budget (line) £



Rolling 14 month pay expenditure - bank and agency £



Pay expenditure year on year £



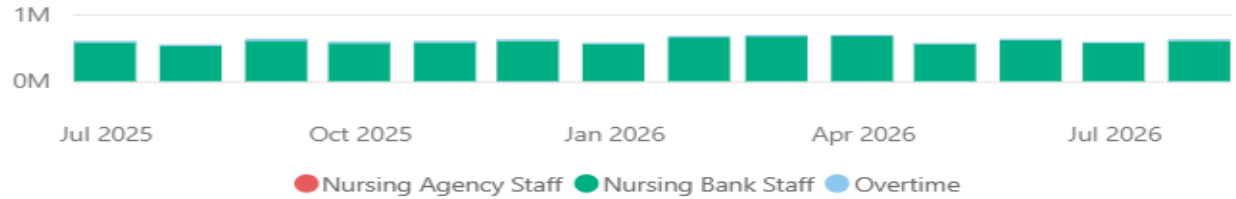
Rolling 14 month temporary pay as a percentage of total pay expenditure £



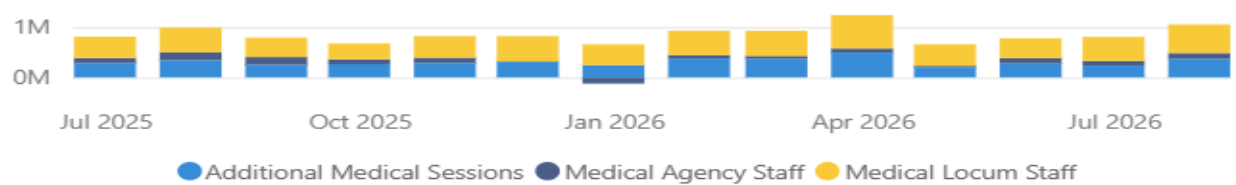
Rolling 14 month pay expenditure - overtime £



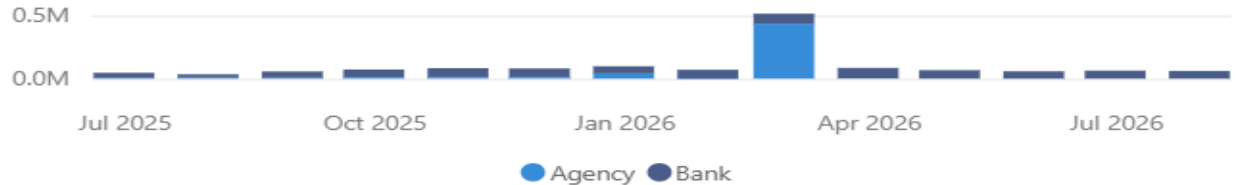
Rolling 14 month nursing pay expenditure - temporary spend £



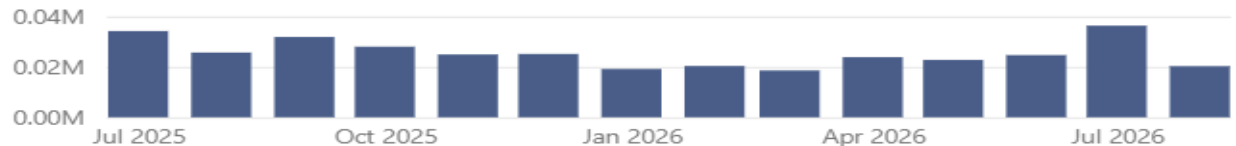
Rolling 14 month medical staff pay expenditure - temporary spend £



Rolling 14 month A&C staff pay expenditure - temporary spend £



Rolling 14 month AHP staff pay expenditure - temporary spend £



Workforce – WTEs by Staff Type August 26

This month, there was an overall increase of 57.8 WTEs. The increase is primarily in substantive nursing (13.8 WTEs) and A&C (28.3 WTEs) with temporary nursing increasing by a further 13.1 WTEs. Medical staff increased by 2.9 WTEs in total.

Substantive staff increased by 44.5 WTEs, Agency by 3.6 WTEs, ECW by the equivalent of 4.2 WTEs and there was an increase of 10.7 WTEs in Bank staff WTEs.

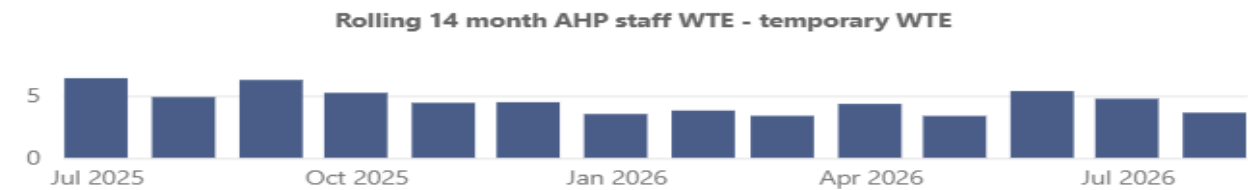
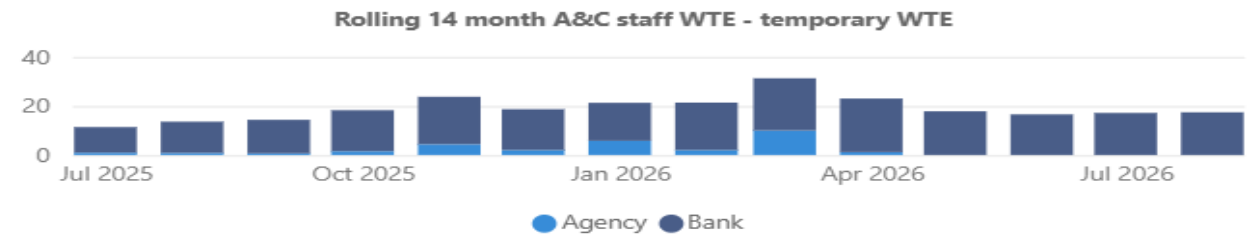
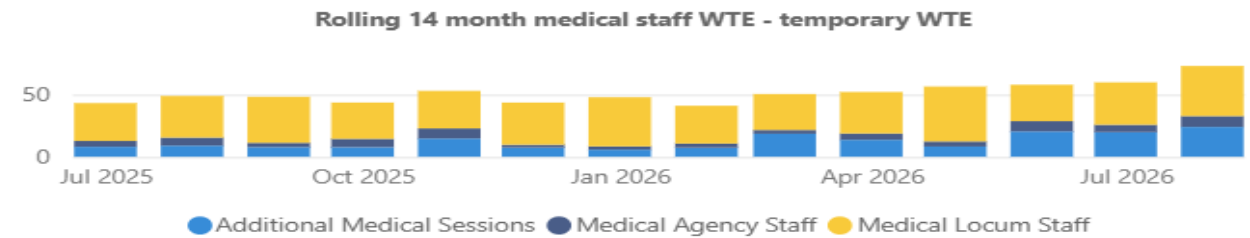
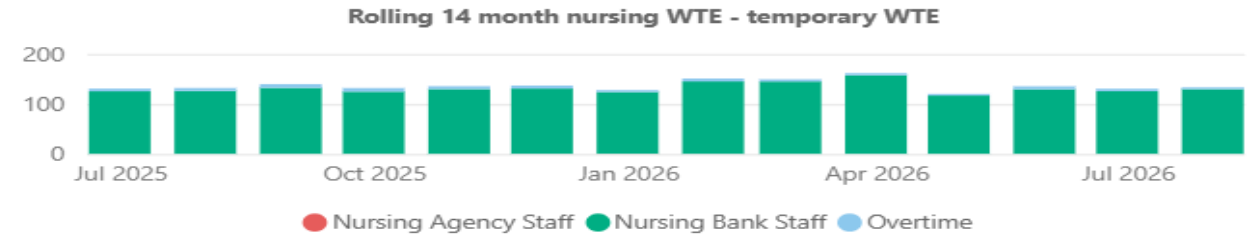
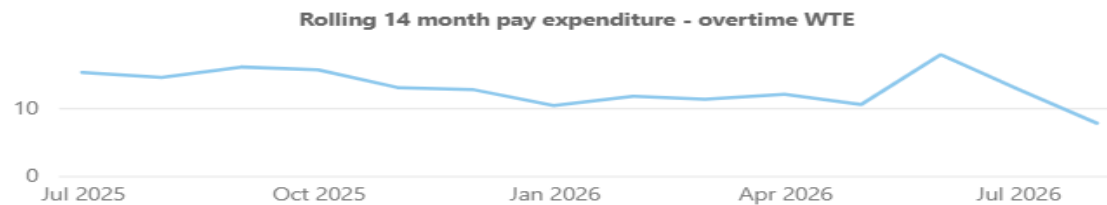
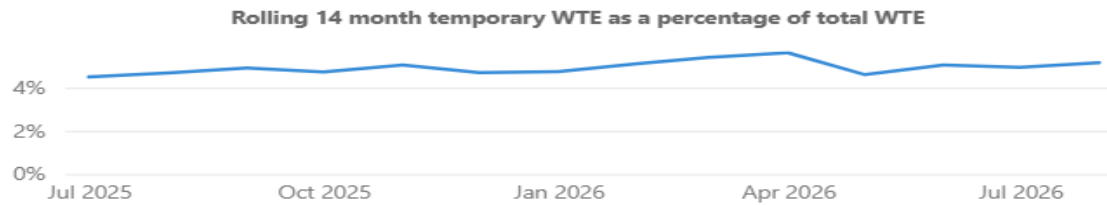
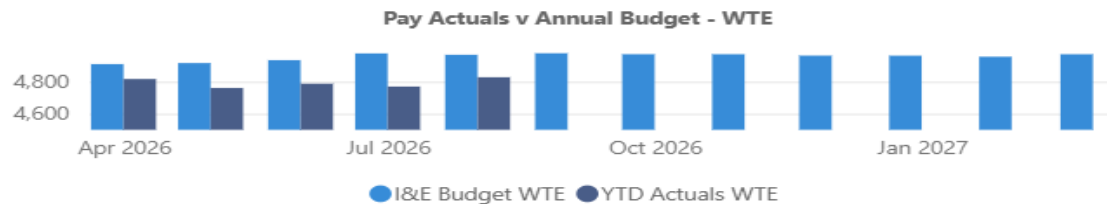
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,880.0	1,887.7	1,903.8	2,079.7	175.9	1,888.1	2,070.6	182.4
	Medical Staff	582.5	597.4	572.3	656.0	83.7	587.6	656.6	69.0
	A&C	853.7	904.7	882.0	952.8	70.8	859.0	954.6	95.5
	AHP	550.3	536.7	549.0	600.8	51.8	546.1	599.6	53.4
	Sci & Professional	283.7	277.6	279.9	323.6	43.6	280.6	322.0	41.4
	Support Staff	281.4	277.8	286.1	297.2	11.1	282.2	295.8	13.6
	Prof & Tech	51.7	48.1	52.7	55.7	2.9	53.9	55.7	1.8
	Other	49.8	48.6	51.8	21.8	-30.0	50.8	-3.9	-54.7
	Unallocated central funding	0.0	0.0	0.0	-43.8	-43.8	0.0	-33.3	-33.3
	Total	4,533.1	4,578.7	4,577.6	4,943.6	366.1	4,548.4	4,917.6	369.2
Overtime	Prof & Tech	4.0	3.7	1.3	3.2	1.8	3.8	3.2	-0.6
	A&C	0.8	0.6	0.4	0.8	0.4	1.0	0.8	-0.2
	AHP	2.0	3.3	0.9	0.0	-0.9	1.5	0.0	-1.5
	Sci & Professional	1.1	1.1	1.4	0.0	-1.4	1.5	0.0	-1.5
	Nursing	4.9	5.8	3.7	0.0	-3.7	4.5	0.3	-4.2
	Total	12.8	14.5	7.7	4.0	-3.8	12.2	4.3	-7.9
Agency	Sci & Professional	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	A&C	0.0	0.9	0.0	0.0	0.0	0.2	0.0	-0.2
	Nursing		0.0						
	Support Staff		0.0						
	Prof & Tech	1.8	1.8	2.6	0.0	-2.6	2.5	0.0	-2.5
	Medical Staff	6.0	6.5	8.7	0.0	-8.7	6.4	0.0	-6.4
	Total	7.7	9.1	11.3	0.0	-11.3	9.2	0.0	-9.2
Additional Medical Sessions	Medical Staff	19.7	9.0	23.9	2.5	-21.4	17.1	1.1	-16.0
	Total	19.7	9.0	23.9	2.5	-21.4	17.1	1.1	-16.0
Bank & Locum Staff	Prof & Tech	0.2	0.2	0.1	0.2	0.1	0.2	0.2	0.0
	Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	AHP	2.8	1.6	2.7	0.3	-2.4	2.8	0.1	-2.8
	Sci & Professional	3.8	5.9	4.8	0.4	-4.4	3.2	0.8	-2.5
	Support Staff	12.6	12.8	11.6	1.8	-9.8	13.2	1.8	-11.4
	A&C	16.4	12.2	17.0	0.4	-16.6	17.2	0.5	-16.7
	Medical Staff	33.9	33.3	40.1	8.3	-31.9	36.1	8.7	-27.4
	Nursing	125.5	126.1	129.5	4.3	-125.2	131.6	4.0	-127.6
	Total	195.1	192.1	205.8	15.6	-190.2	204.4	16.0	-188.4
Total		4,768.5	4,803.3	4,826.3	4,965.7	139.4	4,791.2	4,939.0	147.7

Workforce - WTE (by Staff Group) August 2026

In August 2026 we report an increase of 23.0 WTEs compared to August 2025, including the increases relating to externally funded staff.

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	582.5	597.4	572.3	656.0	83.7	587.6	656.6	69.0
	Additional Medical Sessions	19.7	9.0	23.9	2.5	-21.4	17.1	1.1	-16.0
	Bank & Locum Staff	33.9	33.3	40.1	8.3	-31.9	36.1	8.7	-27.4
	Agency	6.0	6.5	8.7	0.0	-8.7	6.4	0.0	-6.4
	Total	642.1	646.2	645.0	666.7	21.7	647.3	666.4	19.1
Nursing	Substantive	1,880.0	1,887.7	1,903.8	2,079.7	175.9	1,888.1	2,070.6	182.4
	Bank & Locum Staff	125.5	126.1	129.5	4.3	-125.2	131.6	4.0	-127.6
	Agency		0.0						
	Overtime	4.9	5.8	3.7	0.0	-3.7	4.5	0.3	-4.2
	Total	2,010.4	2,019.5	2,036.9	2,083.9	47.0	2,024.2	2,074.9	50.7
Sci & Professional	Substantive	283.7	277.6	279.9	323.6	43.6	280.6	322.0	41.4
	Bank & Locum Staff	3.8	5.9	4.8	0.4	-4.4	3.2	0.8	-2.5
	Agency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Overtime	1.1	1.1	1.4	0.0	-1.4	1.5	0.0	-1.5
	Total	288.5	284.7	286.1	323.9	37.9	285.3	322.8	37.5
A&C	Substantive	853.7	904.7	882.0	952.8	70.8	859.0	954.6	95.5
	Bank & Locum Staff	16.4	12.2	17.0	0.4	-16.6	17.2	0.5	-16.7
	Agency	0.0	0.9	0.0	0.0	0.0	0.2	0.0	-0.2
	Overtime	0.8	0.6	0.4	0.8	0.4	1.0	0.8	-0.2
	Total	870.8	918.3	899.4	954.0	54.6	877.4	955.9	78.4
AHP	Substantive	550.3	536.7	549.0	600.8	51.8	546.1	599.6	53.4
	Bank & Locum Staff	2.8	1.6	2.7	0.3	-2.4	2.8	0.1	-2.8
	Overtime	2.0	3.3	0.9	0.0	-0.9	1.5	0.0	-1.5
	Total	555.1	541.6	552.6	601.1	48.5	550.4	599.6	49.2
Prof & Tech	Substantive	51.7	48.1	52.7	55.7	2.9	53.9	55.7	1.8
	Bank & Locum Staff	0.2	0.2	0.1	0.2	0.1	0.2	0.2	0.0
	Agency	1.8	1.8	2.6	0.0	-2.6	2.5	0.0	-2.5
	Overtime	4.0	3.7	1.3	3.2	1.8	3.8	3.2	-0.6
	Total	57.7	53.8	56.8	59.0	2.2	60.4	59.1	-1.3
Support Staff	Substantive	281.4	277.8	286.1	297.2	11.1	282.2	295.8	13.6
	Bank & Locum Staff	12.6	12.8	11.6	1.8	-9.8	13.2	1.8	-11.4
	Agency		0.0						
	Total	294.0	290.6	297.7	299.0	1.3	295.4	297.6	2.2
Other	Substantive	49.8	48.6	51.8	21.8	-30.0	50.8	-3.9	-54.7
	Total	49.8	48.6	51.8	21.8	-30.0	50.8	-3.9	-54.7
Other	Bank & Locum Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Unallocated central funding	Substantive	0.0	0.0	0.0	-43.8	-43.8	0.0	-33.3	-33.3
	Total	0.0	0.0	0.0	-43.8	-43.8	0.0	-33.3	-33.3
Total		4,768.5	4,803.3	4,826.3	4,965.7	139.4	4,791.2	4,939.0	147.7

Workforce - WTE (trends)



Statement of Financial Position – 31 August 2026

STATEMENT OF FINANCIAL POSITION

	As at	Plan	Plan YTD	Actual at	Variance YTD
	1 April 2026	31 March 2027	31 August 2026	31 August 2026	31 August 2026
	£000	£000	£000	£000	£000
Intangible assets	47,648	37,985	41,828	45,641	3,813
Property, plant and equipment	172,171	205,945	186,211	173,677	(12,534)
Right of use assets	8,088	10,097	8,368	7,447	(921)
Trade and other receivables	5,890	7,162	7,162	5,890	(1,272)
Total non-current assets	233,797	261,189	243,569	232,655	(10,914)
Inventories	7,243	5,000	5,000	4,842	(158)
Trade and other receivables	23,307	16,418	19,418	21,920	2,502
Non-current assets for sale	983	490	490	983	493
Cash and cash equivalents	16,744	3,228	4,228	25,911	21,683
Total current assets	48,277	25,136	29,136	53,656	24,520
Trade and other payables	(40,276)	(41,666)	(39,479)	(46,513)	(7,034)
Borrowing repayable within 1 year	(4,238)	(4,609)	(4,609)	(4,223)	386
Current Provisions	(2,356)	(2,500)	(2,500)	(2,290)	210
Other liabilities	(537)	(2,685)	(2,685)	(2,308)	377
Total current liabilities	(47,407)	(51,460)	(49,273)	(55,334)	(6,061)
Total assets less current liabilities	234,667	234,865	223,432	230,977	7,545
Borrowings	(35,539)	(34,324)	(34,398)	(33,913)	485
Provisions	(326)	(385)	(385)	(104)	281
Total non-current liabilities	(35,865)	(34,709)	(34,783)	(34,017)	766
Total assets employed	198,802	200,156	188,649	196,960	8,311
Financed by					
Public dividend capital	363,968	394,933	377,038	363,967	(13,071)
Revaluation reserve	14,052	12,319	12,319	14,051	1,732
Income and expenditure reserve	(179,218)	(207,096)	(200,708)	(181,058)	19,650
Total taxpayers' and others' equity	198,802	200,156	188,649	196,960	8,311

The table shows the Statement of Financial Position as at 31 August 2026.

The plan was set in March and before the year end position, which included some valuations to fixed assets. As a result there are some variances to plan.

Cash is higher than plan, but includes £2.7m of Public Dividend Capital (PDC) cash specifically allocated to capital projects and has carried over from the prior year. The cash position is still strong from the end of 2025/26. The timing of the final payment run for the month has also caused a higher variance.

Payables has increased since 31 March and is higher than plan. This is due to increased expenditure accruals for both NHS and non-NHS bodies and relates to items that either do not have an invoice, do not have a valid purchase order or where items have not yet been receipted. A working group has been set up to process these legacy items quickly and effectively and before the go-live of the new ledger system in December.

The PDC Reserve is lower than plan due to the phasing of capital projects and the change in some of the expected PDC since the plan was agreed.

The income and expenditure reserve has a lower balance than was anticipated in the plan. This is because an £8m impairment reversal was accounted for at 31 March, along with the improved deficit position. These items were not included in the planned reserve figure, causing this variation.

Better Payment Practice Code (BPPC) – Month 5

August 2026		
Better Payment Practice Code	Total bills paid YTD Performance Number	Total £ paid YTD Performance £'000
Non NHS		
Total bills paid in the year	14,803	72,823
Total bills paid within target	11,729	64,941
Percentage of bills paid within target	79%	89%
NHS		
Total bills paid in the year	585	6,532
Total bills paid within target	281	3,006
Percentage of bills paid within target	48%	46%
Total		
Total bills paid in the year	15,388	79,355
Total bills paid within target	12,010	67,947
Percentage of bills paid within target	78%	86%
Previous month performance	79%	85%

The table shows the Trust's performance to date for 2026/27 against the Better Payment Practice Code. The Code measures the performance of invoices being paid within 30 days. The standard requires that 95% of invoices are paid within the 30 day target.

The performance is measured over the year and the table shows the Trust's performance at month 5. The performance is linked to our cash position and performance over recent months has shown an improvement. However, there has been a decline with the performance of NHS invoices and this is due to the Trust clearing and paying some older invoices that did not have a purchase order or authorisation from the Budget Holder to pay.

As part of the SBS Transformation Project we are working on clearing aged creditors, which may impact on the BPPC in future months.

Capital progress report - Month 5

Capital Spend - 31 August 2026	Year to Date		Full Year			
Capital Scheme	YTD Original Plan	YTD Actual	Funding Split		Full Year Forecast to 31st Mar 2027	Total Full Year Variance Available Funds vs Actual Spend YTD
			Internal	PDC Available		
	£000's	£000's	£000's	£000's	£000's	£000's
**New Hospital Programme	5,360	1,001		12,867	12,867	11,866
***Estates	3,525	3,903	8,462	1,239	9,701	5,798
Digital / IT	1,665	192	4,000		4,000	3,808
*Medical Equipment incl Radiology	625	462	1,500		1,500	1,038
Estates Safety Fund	755	8		1,883	1,883	1,875
RtCS Diagnostics Schemes	95	-		233	233	233
RtCS UEC Schemes	3,125	-		-	-	-
RtCS Community Schemes	1,290	-		3,100	3,100	3,100
Newmarket Endoscopy	2,150	927		5,157	5,157	4,230
****Leases	35	-	2,454		2,454	2,454
Total Capital Schemes	18,625	6,493	16,416	24,479	40,895	34,402
Capital Schemes excluding NHP	13,265	5,492	16,416	11,612	28,028	22,536
Overspent vs Original Plan			40,895			
Underspent vs Original Plan						

* This includes all equipment being purchased across the Trust
 ** NHP budget is subject to change throughout the year and is fully funded by PDC
 *** Estates includes costs associated with RAAC works
 **** Leases includes £1,865k of intra NHS leases that do not impact on CDEL

The Capital Plan for 2026/27 was agreed at £47m. During the first quarter of 2026/27, RAAC funding was also approved of £1.24m and some of the return to constitutional standards (RtCS) bids were rejected, taking the plan to £40.9m for the year. For month 5 the Trust has spent £6.5m against a year-to-date plan of £18.6m. The variance is due to the phasing of the plan, particularly with the New Hospital Programme and the delays with the Theatre Project. The plan also assumes spend on RtCS projects, the funding for which has only just been formally approved.

As capital bids and approvals for 2026/27 are agreed, our Capital Plan for 2026/27 may change.

The Trust is forecasting to achieve it's Capital Plan for 2026/27.

5.3. Winter Planning ATTACHED) (+Appendices)

To Assure

Presented by Matt Keeling

Report to Trust Board

Report information

Report title: Winter Planning and Operational Performance Assurance 2026/27

Agenda item: 5.3

Sponsor/Executive lead: Nicola Cottington, Chief Operating Officer

Report prepared by: Matthew Keeling, Deputy Chief Operating Officer

Previously considered by: Management Executive Group, Finance and Performance Committee

This report is for: ☒ Approval ☒ Assurance ☐ Discussion ☐ Information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☒ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What? This report provides assurance regarding the Trust's preparedness for winter 2026/27 and the associated programme of actions intended to maintain operational resilience and support delivery of planned operational performance trajectories during periods of peak seasonal demand.

The Trust has developed a comprehensive winter preparedness plan bringing together urgent and emergency care improvement, admission avoidance, discharge optimisation, patient flow initiatives, ward reconfiguration, workforce planning, escalation arrangements and business continuity measures. Delivery of these actions is supported through revised Urgent and Emergency Care (UEC) governance arrangements and a clear accountability framework.

The report also presents the Trust's NHS England Winter Planning Board Assurance Statement and Winter Planning Checklist and seeks assurance that the requirements of the national winter planning guidance have been met ahead of Trust Board approval and submission to NHS England.

So what? Historically, winter planning has focused primarily on operational resilience and the Trust's ability to respond safely to periods of increased demand. Whilst this remains a critical objective, the Trust's approach for winter 2026/27

extends beyond resilience alone and seeks to ensure that progress against agreed operational improvement trajectories is maintained throughout the winter period.

The planned interventions are intended to support continued improvement in emergency care performance, reduce delays in patient flow, minimise ambulance handover delays, protect elective activity and reduce length of stay. The implementation of ward reconfiguration proposals and strengthened UEC governance arrangements provide important enabling infrastructure to support these objectives.

What next? Delivery of the winter plan will continue throughout autumn, with progress monitored through a strengthened UEC governance framework alongside the existing Elective Delivery Board's oversight of planned care delivery. The Trust's winter planning, alongside established Business Continuity and Critical Incident arrangements, was tested through the Norfolk and Suffolk ICB winter planning exercise on 08 September 2026. Learning from this exercise has been incorporated into final winter readiness assessments and ongoing delivery plans.

Action required by the board:

The Board is asked to:

1. Receive the report and take assurance regarding the Trust's preparedness for winter 2026/27.
2. Take assurance regarding the arrangements in place to support delivery of operational performance trajectories throughout the winter period.
3. Note the key delivery risks and oversight arrangements associated with implementation of the winter programme.

Governance and compliance

Risk and assurance: The principal risks relate to sustained demand pressures, delayed discharges, workforce availability, implementation of ward reconfiguration plans and delivery of key patient flow initiatives. Mitigating actions are included within the winter preparedness programme and will be monitored through established governance arrangements.

Equality, diversity and inclusion: The actions described within this report are intended to support equitable access to urgent and emergency care services and reduce delays across patient pathways. An Equality Impact Assessment has been included.

Sustainability: The winter plan includes a focus on improving flow, reducing

unnecessary admissions and minimising avoidable lengths of stay, supporting more efficient utilisation of Trust resources and capacity.

Legal and regulatory context: The Trust is required to maintain safe and effective services throughout periods of operational pressure and to demonstrate robust arrangements for emergency preparedness, resilience and response. The measures outlined within this report support these statutory and regulatory responsibilities, assessed through the attached board assurance statements submitted to the NHS England regional office subject to approval by the Board.

Winter Planning and Operational Performance Assurance 2026/27

1. Introduction

- 1.1. This report provides an update on preparations for winter 2026/27 and seeks to provide assurance that the Trust has established the necessary arrangements to manage winter pressures whilst maintaining progress against agreed operational performance trajectories.
- 1.2. The report should be read alongside the detailed winter plan and board assurance statements included as Annex A and Annex B.

2. Background

- 2.1. Winter periods continue to present significant challenges for all NHS providers through increased demand, higher acuity, workforce pressures and constraints across health and social care systems.
- 2.2. In response, the Trust has developed a winter preparedness plan designed to strengthen existing operational resilience, improve patient flow and maximise available capacity. The programme aligns operational improvement priorities with winter planning objectives to ensure that winter actions contribute directly to sustained performance improvement rather than solely providing short-term resilience measures.

3. Demand Management and Admission Avoidance

- 3.1. The Trust has developed a range of interventions intended to reduce avoidable admissions and maximise the use of alternatives to inpatient care. These include:
 - Optimisation of Same Day Emergency Care pathways.
 - Development of admission avoidance arrangements at the emergency department front door.
 - Expansion of Virtual Ward utilisation.
 - Maximisation of Community Assessment Bed capacity.

- Strengthened collaboration with primary care and community partners.
- Enhanced use of ambulatory pathways.

3.2. Collectively, these schemes are intended to reduce pressure on inpatient capacity and support delivery of emergency care performance standards throughout winter.

4. Patient Flow and Capacity

4.1. A significant proportion of the winter programme focuses on discharge optimisation and reduction in internal delays. Key initiatives include:

- Expansion of Criteria Led Discharge.
- Implementation of a Continuous Quality Improvement programme facilitated by Stop-Stop-Go.
- Reduction in long-stay patients.
- Enhanced therapy and discharge support.
- Strengthened specialty ownership of patient flow.
- Daily oversight of discharge and escalation processes.

4.2. These initiatives are supported by a proposed ward reconfiguration to provide additional flexibility within the inpatient bed base for elective patients, strengthen discharge capacity and improve utilisation of Same Day Emergency Care services.

4.3. The Trust has established robust day-to-day operational management arrangements through its Command, Control and Coordination (C3) framework and Tactical Patient Flow Escalation Plan. Operational pressures, patient flow, bed capacity and discharge performance are monitored continuously through the Tactical Control Centre and a defined programme of operational and tactical capacity meetings. The arrangements align with the national OPEL framework and provide a clear escalation pathway from business-as-usual through to tactical and strategic command arrangements where required. This enables the Trust to maintain oversight of demand and capacity pressures, coordinate timely interventions, support safe and effective patient flow, and maintain organisational resilience throughout the winter period.

4.4. During 2026 the Trust has undertaken formal After Action Reviews following a major power outage, a critical ventilation failure affecting the Recovery Unit and a period of extreme heat which resulted in operational disruption and elective activity cancellations. These reviews demonstrated the effectiveness of the Trust's incident response arrangements whilst identifying opportunities

to strengthen escalation processes, communication, business continuity planning and infrastructure resilience. Agreed actions are being tracked through the Trust's resilience governance arrangements and have directly informed winter preparedness planning, providing assurance that learning from operational incidents is translated into tangible improvements in organisational resilience.

5. Emergency Preparedness, Resilience and Response (EPRR)

Assurance

- 5.1. Alongside winter planning arrangements, the Trust is currently undertaking its annual NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment. In 2025/26 the Trust achieved an overall compliance score of 96.8%, with only two standards assessed as partially compliant: the Data Protection and Security Toolkit (DPST) and Responder Training.
- 5.2. Early indications from the 2026/27 assessment suggest that the Trust will maintain a high level of compliance across the EPRR framework. The Trust expects to achieve full compliance with the Data Protection and Security Toolkit following completion of an agreed improvement programme and submission of additional evidence. In relation to responder training, significant progress has been made through the development of structured digital competency portfolios for Tactical and Strategic Commanders aligned to the NHS England Minimum Occupational Standards. These portfolios provide a mechanism for recording training, exercising activity, incident experience and continuing professional development, strengthening assurance regarding command capability and organisational resilience.
- 5.3. The annual EPRR assurance process provides independent evidence that the Trust has mature arrangements in place for emergency preparedness, business continuity, incident response, command and control, training, exercising and organisational resilience. The findings of the assessment, together with improvements arising from the action plan, have informed the Trust's winter planning arrangements and provide additional assurance regarding organisational readiness for periods of increased operational pressure.
- 5.4. The anticipated improvement in both areas of previous partial compliance provides confidence that the Trust is moving towards full compliance with all applicable NHS England EPRR Core Standards.

6. Maintaining Operational Performance Trajectories

6.1. The Trust has deliberately aligned winter planning activities with delivery of its operational improvement plans. The winter plan is expected to support:

- Improvement in emergency department performance.
- Reduction in 12-hour waits.
- Improved ambulance handover performance.
- Reduced average length of stay.
- Improved bed occupancy and flow metrics.
- Protection of elective activity and recovery trajectories.

6.2. This represents a shift from a traditional winter planning approach focused primarily on resilience, towards a more integrated approach that supports both resilience and performance improvement.

7. Governance and Delivery Oversight

7.1. Implementation of the winter programme is supported through strengthened UEC governance arrangements, including clear executive sponsorship, operational ownership and performance monitoring. A two tiered structure of a UEC Delivery Board with the UEC Delivery Group reporting into it is aligned to and creates an equivalent of the governance structure in place for elective delivery.

7.2. Progress will be monitored through established reporting arrangements, enabling timely identification of emerging risks and corrective actions where required – the analysis of leading and lagging indicators will be the role of the UEC Delivery Board which will ensure projects and actions to recover and deliver performance trajectories are proportionate and aligned.

7.3. The Trust's preparedness arrangements, alongside those of system partners was tested through the Norfolk and Suffolk ICB winter planning exercise on 08 September 2026. Lessons identified will be incorporated into ongoing winter delivery plans and preparedness assessments at provider and system level.

8. NHS England Winter Planning Board Assurance Statements

8.1. In line with NHS England requirements, the Trust has completed the 2026/27 Winter Planning Board Assurance Statement and accompanying Winter Planning Checklist. The self-assessment demonstrates that the Trust has established appropriate governance, escalation arrangements, surge capacity planning, patient flow initiatives, workforce resilience measures, infection prevention and control arrangements, and operational command structures to support delivery of safe and effective services throughout the winter period.

- 8.2. The Board Assurance Statements have been developed through a multidisciplinary process involving operational, clinical and corporate teams and reflect the Trust's wider winter planning programme. The submission demonstrates how winter preparedness has been integrated with urgent and emergency care improvement, discharge optimisation, elective recovery, workforce planning, business continuity arrangements and system-wide operational planning.
- 8.3. The Trust participated in the Norfolk and Suffolk system-level winter planning exercise during September 2026, learning re-emphasised the importance of system working to mitigate patient safety and quality risks across organisational boundaries and ensuring that recovery planning is delivered alongside incident response.
- 8.4. The Trust maintains established infection prevention and control arrangements, including requirements relating to PPE provision and FFP3 fit testing during periods of increased respiratory disease transmission. 30 fit testers have been trained, with compliance monitored through the Health and Safety Committee and escalated if required through the Corporate Risk Governance Group. Testing is currently ongoing with 42% of staff requiring testing having had this completed with a pass rate of 97%. The Trust can rapidly expand testing activity should requirements increase over winter.
- 8.5. An equality impact assessment shows no significant adverse impact has been identified for any protected characteristic group. The plan is expected to have an overall positive impact through improved patient flow, reduced waiting times, enhanced access to urgent and emergency care services, strengthened community pathways and improved discharge arrangements. Potential risks relating to digital exclusion, discharge planning and access to community-based services have been identified and mitigating actions have been incorporated. The Equality Impact Assessment will be reviewed should there be any material changes to the Winter Plan or emerging evidence of differential impact on protected groups.

9. Next steps

- 9.1. Between September and November 2026 the Trust will:
- Complete implementation of agreed winter actions.
 - Deliver planned ward reconfiguration changes.
 - Embed revised UEC governance arrangements.
 - Monitor delivery milestones and operational performance indicators.
 - Incorporate lessons arising from system winter exercising.
 - Continue to review capacity, escalation and business continuity arrangements throughout the winter period.

10. Conclusion

- 10.1. The Trust has developed a comprehensive winter preparedness programme which combines operational resilience, patient flow improvement, capacity optimisation, discharge initiatives, ward reconfiguration and strengthened governance arrangements.
- 10.2. The principal risks to successful delivery relate to sustained demand exceeding forecast assumptions, workforce availability, respiratory viral prevalence, and system discharge capacity. These risks are mitigated through established escalation arrangements, daily Tactical Control Centre oversight, mutual aid arrangements and business continuity plans.
- 10.3. Whilst risks associated with winter demand cannot be eliminated, the planned interventions provide a credible basis for both maintaining operational resilience and supporting delivery of agreed operational performance trajectories throughout winter 2026/27.
- 10.4. The majority of proposed winter actions will be delivered within existing resources, with any schemes requiring additional investment subject to separate business case approval and affordability assessment.
- 10.5. Taken together, the operational actions described within this report, the supporting governance arrangements, lessons identified through incident response and exercising, and the high levels of compliance demonstrated through both the Winter Planning Board Assurance Statement and annual EPRR Core Standards assessment provide assurance that the Trust is well prepared for winter 2026/27 and has robust arrangements in place to respond to periods of increased operational pressure

11. Recommendations

- 11.1. The Board is asked to:
 - Take assurance from the progress made in preparing for winter 2026/27.
 - Take assurance that the winter preparedness programme is designed to support delivery of operational performance trajectories as well as operational resilience.
 - Note the key risks, dependencies and governance arrangements associated with delivery of the programme.
 - Review and recommend to the Trust Board approval of the NHS England Winter Planning Board Assurance Statements and associated Winter Planning Checklist.

ANNEX A: WSFT Winter Plan Actions

ANNEX B: Board Assurance Self Assessment

ANNEX C: Winter Planning Equality Impact Assessment

6. FIT FOR TOMORROW

6.1. Future system board report (ATTACHED)

- Update on build
- Update on transformation
- Update on digital programme

To Assure

Presented by Jonathan Rowell

Public Board	
Report title:	Programme Director's Update
Agenda item:	6.1
Date of the meeting:	25th September
Sponsor/executive lead:	Jonathan Rowell
Report prepared by:	Gary Norgate

Purpose of the report			
For approval ☒	For assurance ☐	For discussion ☐	For information ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive Summary
WHAT? <i>Summary of issue, including evaluation of the validity the data/information</i>
The project to replace the current West Suffolk Hospital is formally a Scheme within the national New Hospitals Programme (NHP). The following report provides an overview of progress being made towards our goal to build a sustainable new hospital for West Suffolk. The key points to note since the last meeting are: • The outline business case (OBC) was successfully submitted To the New Hospital Programme (NHP) on 15th September. This will allow it to be formally considered by NHP Investment Committee in October. • The business case covering the lease of the proposed construction compound has been agreed. • The latest cost plan has been developed following completion of RIBA 3¹ and the current position supports submission of an affordable OBC within the scheme's agreed funding parameters. • The OBC was systematically presented to Trust Board and the Integrated Care Board (ICB) and an agreed, formal letter of support for the case presented has been received. • Dragados, the Trust's allocated construction partner, are now working closely with the Trust and its advisors. • Dragados are on track to deliver interim reports on the Trust's RIBA 3 designs and costs at the end of September. Work shared thus far does not indicate any "red-flags". • Within the RIBA 3 designs there are a small number of outstanding challenges that will be worked through before the next phase of design commences in October. (details below). • The Autumn "stock take" meeting with Trust, ICB, Regional and NHP leadership took place and firm support for the scheme was unanimously confirmed.
SO WHAT?

¹ RIBA3 refers to the Royal Institute of British Architects defined design stage during which the layouts of the departments within the new hospital are coordinated with the utilities that serve them.

Scheme Status

A series of “stock take” meetings have been established by the leaders of the new hospital program (NHP) to aid teams in the progression of their projects. The meetings involve senior leaders from the Trust, The East of England regional team, the Norfolk and Suffolk Integrated Care Board and NHP. The first of these meetings set out a number of conditions that, once met, would clear the way for the West Suffolk scheme to progress. The following table demonstrates how each of the conditions have been met.

Stocktake Condition	Outcome / Progress
Optimise costs to align funding requirements with capital allocation	Complete – RIBA3 cost forecasts are aligned to capital allocation and contingencies.
Optimise Staff and Public flows and identify service pinch points in the new hospital	Complete – independent review completed by Deloitte, analysing flows and allowing optimisation.
Review of vertical transport strategy	Complete – Mott McDonald have reviewed lift strategy, allowing optimisation.
Confirm external location of energy infrastructure, plant room layouts.	Complete – all energy infrastructure is externally located.
Revisit demand modelling and ensure it remains current.	Complete

The satisfactory completion of these conditions does not represent a compromise of our design and has allowed us to submit our OBC on time. This will now be formally considered by the NHP Investment Committee in October.

OBC Progress and funding

The successful and timely submission of the OBC allows a month for the case to progress through NHP governance before being formally heard by NHP Investment Committee in October.

Critical to the success of this case is the ability for the Trust design to be delivered within the formal capital allocation (between £1.2 and £1.5bn). Following appointment of our contractor, WSFT, Dragados and NHP teams were asked to revisit the cost forecast and work together to determine ways in which the experience of Dragados could be applied to optimise costs without compromising design.

This has resulted in a forecast cost that is aligned to our capital allocation.

Design development

Independent of the design / cost optimisation discussed above, our ongoing clinical reviews, coupled with the advice associated with the recent national maternity reviews, have resulted in the following adjustments being collaboratively considered. This work will be complete by end of September, allowing prompt progression into the next design stage without incurring material increase in cost or gross internal floor area.

- 1) Maternity Department – discussions between the Trust’s maternity practitioners and NHP have determined that a dedicated theatre should be integrated into the maternity department. There will also be an increase in bed numbers. A new design that fits these changes into the H2.0 template without increasing floor space / cost has been drawn and is being socialised.
- 2) Post Ockenden / Amos reviews, NHP have issued a mandate that the Maternity Assessment Unit must be separated from the birthing area. This is being worked through with architects and relevant WSFT clinical teams.
- 3) Radiology – a decision to move the interventional radiology function from the main theatre block to the radiology department has been taken. We are currently working through this in the form of a 3-week sprint with the support of the design team, local stakeholders and NHP.
- 4) Theatres – as a consequence of the two changes above, the final theatre layout and flow are to be determined by Mid-September.

- 5) Critical Care – a revised design solution regarding the layout within the critical care department has been discussed and drawn.

Finance

The Programme is progressing within its NHP allocated development budget and has been fully funded to deliver RIBA stages 2 and 3 and the Outline Business Case. The team remains fully funded for the remainder of this financial year and work is underway to scope the activities that will determine the funding required for 27/28.

Dragados are employed under a fully funded “Stage 0”² contract. This work will complete around December and a new “Stage 1” agreement is being sought. This agreement will reflect a defined set of activities at a defined price. The agreement will be triggered by a formal “notice to proceed”, the nature and timing of which are being discussed with NHP.

WHAT NEXT?

Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

- OBC Heard by NHP IC - October.
- Stage 1 Design (RIBA4 – led by Dragados) –October 2027 –Jan 2028
- FBC – October 2027 – May 2028
- Building Safety Act – December 2027 – July 2028
- Main Construction – July 2028 – October 2032
- Fit out and Occupation – October 2032 – April 2033

Action Required

The Board are asked to note the content of this report.

Risk and assurance:	The strategy for a new hospital is being developed in line with NHS 10 year Plan, ICB Forward Plan, NHP H2.0 design and WSFT Clinical and Care Strategy. The primary risks are associated with time, capital and operational affordability and aligning optimal design with the need to transform.
Equality, Diversity and Inclusion:	The design and assurance process has been based on an ongoing strategic principle of fully inclusive co-production.
Sustainability:	The design and business case reflect and support the outputs from the recent sustainability review. The associated plans for transformation will ensure the target operating model of the Trust is sustainable.
Legal and regulatory context	The project is underpinned by the terms of NHP Alliance Agreement.

² Stage 0 refers to a set of activities aiming at assuring the RIBA3 design and cost. Completion of this stage ensures that the construction partner can confidently assume responsibility for the detailed design that will be produced in Stage 1 / RIBA4.

GOVERNANCE

6.2. Governance report (ATTACHED)

To Assure

Presented by Paul Bunn

Open Board of Directors – 25 September 2026

Report information

Report title: Governance report – General Update: August - September 2026

Agenda item: 6.2

Sponsor/Executive lead: Jude Chin, Chair/Ewen Cameron, CEO

Report prepared by: Paul Bunn, Acting Trust Secretary

Previously considered by: Standing Board Agenda item

This report is for: ☐ Approval ☒ Assurance ☒ Discussion ☐ Information

This report supports the following ambitions within the organisational strategy:

- | | |
|--|--|
| ☒ High quality care | ☒ Joined up services |
| ☒ Empowered to improve | ☒ Responsible with resources |
| ☒ Fit for tomorrow | |

Executive summary

What?

This paper provides the Trust Board with an update on governance arrangements for the period August – September 2026 as well as referencing future work.

The Trust continues to operate within its statutory and regulatory framework and no issues of escalation need to be raised.

This paper consolidates governance updates from subcommittees including: Senior Leadership Team; Management Executive Group, as well as providing updates from the Council of Governors; and highlights from the Board development session. It supplements the information provided from the CKI's from the four Assurance Committees and the audit committee.

In summary:-

- No urgent decisions have been made between board meetings.
- The Trust's seal has been used on one occasion for a land transaction.
- **Appendix 1**, highlights the Trust current governance structure. There is work underway to strengthen QI and strategy and transformation portfolios within the structure.
- QPS has undergone an effectiveness review and work is underway between Chair, Medical Director, Chief Nurse and Acting Board Secretary to ensure future work programme and deep dive topics are appropriate.
- **Appendix 2**, provides an overview of the 10 top organisational risks. Top three risks (long waits in ED; elective delays times; and cyber security) are discussed below.
 - QPS and Audit Committee monitor the alignment of top clinical risks across the divisions with the current risk register.

- The Executive team continue to have monthly oversight of all risks through the Executive Risk Oversight Group.
- **Appendix 3** contains the Board matrix and forward plan for the rest of 2026/27.
- By way of assurance and to demonstrate effective decision-making:
 - MEG has met regularly and discussed a wide portfolio of work.
 - SLT has met once to focus on cyber awareness and Norfolk and Suffolk Strategic Commissioning Toolkit.
 - The Council of Governors continues to fulfil its statutory obligations, with no issues to escalate.

So what?

The Board is accountable for the quality of care, financial stewardship, and compliance with NHS England and CQC standards. This report supports the Board in maintaining oversight of key activities and developments relating to organisational governance.

What next?

1. Finalise the Agenda for October Board Workshop and work with CPO/Chair on future forward plan.
2. Continue work with strategy and transformation team to develop QI governance and enabling strategies oversight – November 2026.
3. Continue to refine executive risk oversight group and organisational wide risk register
4. Work with QPS chair and executives on QPS agenda and portfolio – November 2026
5. Continue to refine report writing post Ockenden and Amos reviews to strengthen governance – April 2027
6. Continue to liaise with Council of Governors over its future as we proceed through the election process and report on updates - April 2027.

Action required by the board:

The Board is asked to discuss and note the content of the report.

Governance and compliance

Risk and assurance: Effective risk management processes support the operational and strategic performance of the trust by identifying risks and mitigating them effectively. Links to the entire BAF.

Equality, diversity and inclusion: No EDI issues have been identified specifically arising from this governance report. It reports on other workstreams that have undertaken EDI assessments where applicable.

Sustainability: Decisions should not add environmental impact, oversight of workforce should help succession planning.

Legal and regulatory context: NHS Act 2006, Health and Social Care Act 2013, NHS Code of Governance, WSFT Constitution.

Governance report – General Update: August - September 2026

1. Governance update

There have been no major changes within the governance structure since the last report. The new CKI's have been adopted and continue to embed into work programmes.

The Board assurance committees have met and continue to deliver the portfolio of work as per the work programme and agenda. Work continues to define the subcommittee structure that underpins the board assurance committees. **Appendix 1** maps the current committee structure. After reviewing the QPS structure earlier in the year, efforts now are focussed on capturing the work of the strategy and transformation team within the reporting structure to POD and HR post restructure.

Governance team also working to ensure the future systems work is starting to be mapped into the existing committee structure and forward plans, along with updates on the enabling strategies, which are referenced in the earlier strategic priorities update (item 2.1).

Preparations for the Annual Members Meeting on 25 September 2026 are complete. It is hoped the evening was a success and initial verbal feedback/reflections will be provided to Board.

We continue to reflect on recommendations from Ockenden/Amos/Thirwell and continue to work with all colleagues, particularly maternity, to refine reporting to ensure focus on discussion on the right areas.

2. Senior Leadership Team (SLT)

The Senior Leadership Team (SLT) meeting scheduled for August was cancelled due to operational pressures and annual leave of attendees.

The agenda for the 21 September 2026 meeting is:

- Cyber Awareness Session – When cyber becomes clinical - Rootshell Security
- Norfolk and Suffolk Strategic Commissioning Toolkit – Richard Watson and Lizzie Mapplebeck.

3. Management Executive Group (MEG)

The Management Executive Group has met every Wednesday except in Board assurance committee week. This provides a forum for discussion of strategic and operational matters as well as a forum for escalating emerging themes. A snapshot of the non-commercially sensitive matters reviewed include:

- Stakeholder engagement; M365 copilot licences for use in tactical; car parking tariff review; SLT forward plan review; admin transformation update; review and approval of various business cases, review of the business planning framework for next year; review of progress against internal audit management actions; ward configuration and review of winter planning; AVT trial update and an update on SBS transformation.

4. Council of Governors report

The Council of Governors (COG) last met on 10 September 2026. No matters are escalated to the Board. The governor election process is underway and a timetable has been agreed with COG to ensure elections are complete by 1 December 2026.

There have been no further updates on the future of the COG. The Health Bill continues to make its way through Parliament and we await guidance on the future impact. Informal discussions about engagement are taking place.

5. Board development

On 28 August 2026, the Board Development session focused in the morning on managing employment hearings effectively, which was led by Birketts LLP. There then followed a dedicated session on the outline business case for the new hospital. In the afternoon, the Board looked at what it needs to do to prepare for successful transformation, in a session led by the Director for Strategy and transformation.

Work is underway to complete the agenda for 9th October 2026 Board development session. It is the Board's intention to continue work on developing the culture we need at WSFT and defining that into a statement and principles linked to the strategy during future sessions.

6. Risk

There are currently 61 risks captured on the risk register. 10 Organisational wide risks (**Appendix 2**) and 51 clinical (divisional assigned risks). The position in July 2026 was: 7 organisational risks and 48 divisional risks. This shows the risk register is not static and is maturing.

The organisations top risks are:

1. RSK 070 – long waits in ED, this is currently scored at 12 (**Amber**) but is in the process of being reviewed where score will increase due to recent work identifying the level of harm associated with delays.
2. RSK 224 – risk of harm due to delays with elective care and diagnostic pathways (**Score 16**).
3. RSK 221 – cyber security risk (reviewed by DDAC and not reproduced here to prevent cyber security threat).

Regarding the other organisational risks:

- Executive team are working with Estates to capture an organisational estates risks including how adverse temperatures impact on patient care.
- Infection control risks: RSK187 and 221 will be merged into one risk by next meeting (**both score 12**)
- The possible failure to deliver the 2026/27 CIP plan (RSK 228 – scored 16) is in the process of being downgraded based on work with ICB. There is a high degree of confidence of meeting the CIP plan.

There are no red risks reported at divisional level currently. All 51 risks have a current score of 12 (amber) and continue to be reviewed through the PRM process and at monthly divisional governance meetings. There is an even spread of risks across the Divisions.

7. Urgent decisions by the Board

No urgent decisions have been requested. One written resolution, approving the outline business case for the new hospital has been approved since the board last met.

8. Use of Trust Seal

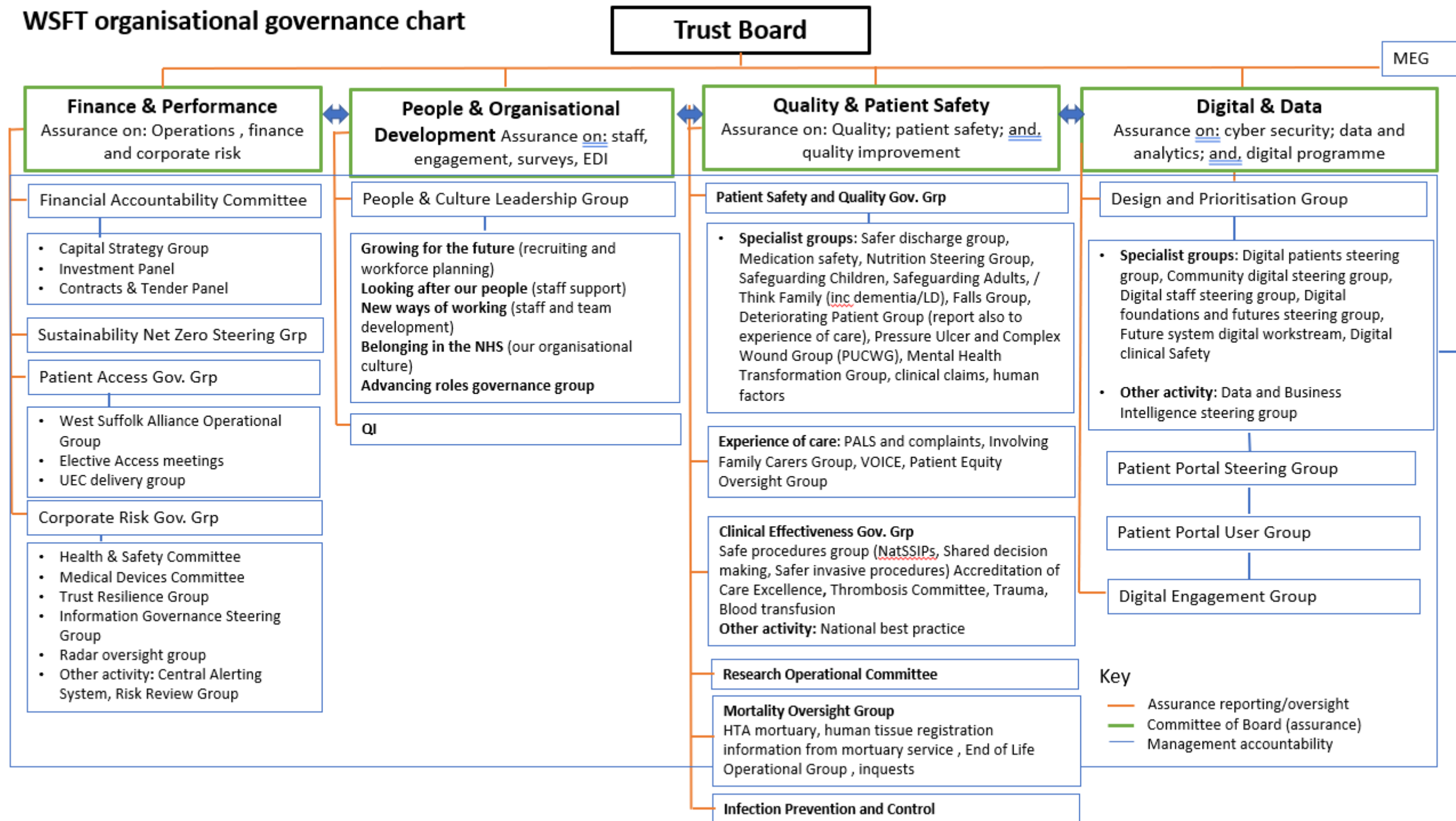
The Trust seal has been used on one occasion (29 August 2026) in respect of a Land Registry transaction around the sale of land subject to a lease at Glemsford surgery.

9. Agenda Items for the Next Meeting

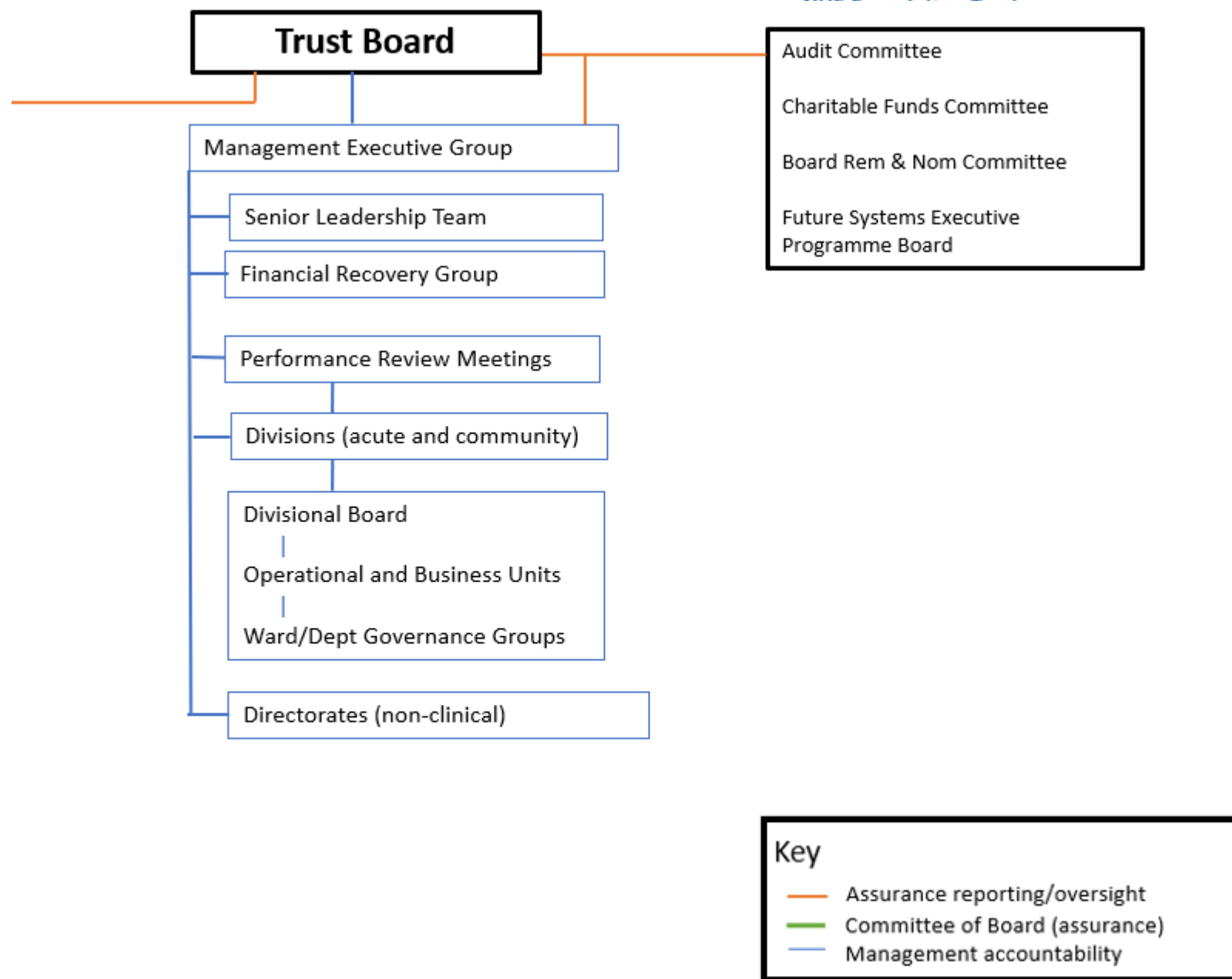
Appendix 3 – is the refreshed and revised Board Matrix and forward plan for 2026/27. This has been benchmarked against other Trusts and aligns with the work programmes of the respective assurance committees and new Trust strategy. The final agenda for each meeting will be drawn up from this matrix and approved by the Chair after discussions with the Executive team.

Appendix 1 –

WSFT organisational governance chart



Compassionate care,
healthier communities



Appendix 2 – Organisational wide risks


Org risk
register.Sept2026.xls

Compassionate care,
healthier communities

6.3. Annual Health & Safety Report (including fire incidents, complaints and claims) in review of modern slavery statement (ATTACHED)

Presented by Jonathan Rowell

Meeting/committee title: Trust Board

Report information

Report title: Health and Safety Annual Board Report

Agenda item:

Sponsor/Executive lead: Neil Jackson Associate Director of Estates and Facilities/
Paul Dunn Trust Secretary

Report prepared by: Neil Jackson Associate Director of Estates and Facilities
and Mike Dixon Health, Safety and Risk Manager

Previously considered by:

This report is for: ☐ Approval ☒ Assurance ☐ Discussion ☒ information

This report supports the following ambitions within the organisational strategy:

- ☒ High quality care ☐ Joined up services
- ☒ Empowered to improve ☒ Responsible with resources
- ☒ Fit for tomorrow

Executive summary

What?

This annual report provides assurance on the Trust's health and safety performance during 2025/26. The report draws on data from Radar Healthcare, statutory reporting processes, workplace inspections, specialist service reports and Occupational Health records. The information presented is considered robust and provides a comprehensive overview of organisational performance. Key themes include effective governance arrangements, continued development of risk management processes, and ongoing challenges relating to violence and aggression towards staff, moving and handling incidents, and slips, trips and falls.

So what?

The report provides assurance that the Trust continues to meet its statutory health and safety responsibilities and maintains effective systems for identifying, managing and mitigating risk. Overall performance remains positive, with strong compliance across key areas including fire safety, specialist services and risk management. However, increasing levels of violence and aggression towards staff, together with rising moving and handling incidents, present ongoing workforce, operational and reputational risks that require continued focus and targeted intervention.

What next?

The Trust will continue to strengthen its health and safety arrangements through the further development of Radar Healthcare, targeted action to reduce violence and aggression towards staff, enhanced support for affected staff, increased fit-testing capacity, completion of outstanding fire audits and risk assessment reviews, and ongoing monitoring of areas with higher rates of musculoskeletal injury. Progress will be monitored through the Health and Safety Committee and reported through established governance arrangements to provide assurance regarding the effectiveness of improvement actions.

Action required by the board: To note update and comment on the assurance provided

Governance and compliance

Risk and assurance

The Trust continues to maintain effective health and safety governance, supported by the Radar Healthcare risk management system. Key risks remain violence and aggression towards staff, moving and handling incidents, and slips, trips and falls. Ongoing monitoring, workplace inspections and specialist assurance processes provide confidence that risks are being actively managed.

Equality, diversity and inclusion

The Trust is committed to providing a safe and supportive working environment for all staff. Work continues to address violence, abuse and harassment, alongside enhanced staff support through Occupational Health and engagement with staff networks.

Sustainability

Effective health and safety management supports workforce wellbeing, reduces sickness absence, and strengthens operational resilience. Programmes focused on injury prevention, occupational health support and safe waste management contribute to the Trust's long-term sustainability objectives.

Legal and regulatory context

The Trust remains compliant with its statutory health and safety obligations, including RIDDOR reporting, fire safety legislation and specialist regulatory requirements such as IR(ME)R. Regulatory inspections and reporting processes continue to provide assurance that legal requirements are being met.

Health and Safety Annual Board Report

1. Introduction

This report provides an overview of the Trust's health and safety performance during 2025/26. It outlines the effectiveness of current governance arrangements, risk management processes, incident reporting, regulatory compliance, and key areas of operational health and safety performance. The report also highlights emerging issues and areas requiring continued focus.

2. Background

The Trust's health and safety performance is monitored through the Health and Safety Committee, with significant concerns escalated to the Corporate Risk Governance Group, Finance and Performance Committee, and Board of Directors as appropriate.

The introduction of Radar Healthcare in April 2024 replaced Datix and has enhanced the Trust's approach to risk management. The system provides dedicated functionality for recording risk assessments, incident reporting, and management of the Trust risk register.

Radar Healthcare has enabled:

- A dedicated repository for risk assessments.
- Improved oversight of divisional risks.
- Enhanced monitoring and management of incidents and actions.
- Greater assurance through a single Trust-wide risk management platform.

3. Health and Safety Areas and Key Issue

3.1 Risk Management

Risk Assessment Events

The Trust uses the Radar Healthcare risk assessment event type to record significant local risks, including:

- Equipment failures.
- Slips, trips and falls.
- Workplace inspection findings.
- Staffing concerns.

Since implementation, 1,570 risk assessments have been recorded.

Risk Register

The Trust continues to strengthen its risk management framework through the Radar Healthcare risk register. All Divisions are responsible for recording, monitoring and reviewing significant risks and ensuring associated risk assessments are linked appropriately.

Since launch, 201 risks have been recorded within the system.

3.2 Workplace Inspections

Workplace inspections are undertaken by Health and Safety Link Persons qualified to RSPH Level 2 Award in Health and Safety. Currently, 398 staff members have achieved this qualification.

Issues identified through inspections are recorded in Radar Healthcare, enabling action tracking and monitoring.

3.3 RIDDOR Performance

Between April 2025 and March 2026, 20 incidents were reported to the Health and Safety Executive (HSE), one fewer than the previous year.

Trends

Category	2024-25	2025-26
Moving and Handling	6	10
Slips, Trips and Falls	4	5
Health and Safety	7	1
Violence and Aggression	0	4
Needlestick	3	0
Asbestos	1	0

Key areas of concern include:

- Increase in moving and handling incidents.
- Increase in slips, trips and falls.
- Increase in violence and aggression-related incidents.

Positively, there were reductions in health and safety incidents, needlestick injuries and asbestos-related incidents.

Of the 20 RIDDOR reports:

- 17 (85%) were due to absences exceeding seven days.
- 2 (10%) related to specified injuries.
- 1 (5%) related to a dangerous occurrence.

3.4 Incident Reporting and Violence Reduction

During 2025/26:

- 1,643 health and safety incidents were reported.
- This represented a 5% increase (76 incidents) compared to the previous year.
- 291 violence, abuse and harassment incidents were reported.
- 92 incidents involved physical assault, broadly unchanged from the previous year.

The Trust continues to work with staff networks to improve support arrangements and is reviewing management of unacceptable behaviour beyond the signposting and sanctions policy that is already in place.

Key Issue

Violence, abuse and aggression towards staff remains a significant health and safety concern. Whilst many incidents are associated with clinical factors such as dementia, mental health conditions, behavioural presentations or confusion, the increase in reported incidents highlights the need for continued focus on staff safety, prevention measures and organisational support arrangements.

3.5 Manual Handling and Musculoskeletal Injuries

Work-related musculoskeletal (MSK) absence remains relatively low, with 24 days lost recorded. However, A&E, Theatres, and Wards G10 and G3 continue to be identified as areas with higher levels of work-related injury risk.

The Ergonomic Health Team and Occupational Health Physiotherapy Service continue to provide support through workplace assessments, equipment provision and early intervention.

3.6 Fit Testing

The Trust currently has:

- 30 trained fit testers.
- 622 staff meeting fit-testing standards for respiratory PPE.

Further work is planned to increase capacity across all Divisions.

3.7 Fire Safety

Fire safety performance remains positive:

- 162 fire risk assessments are current.
- 14 require review.
- 107 trained fire wardens are in place.
- 164 of 185 required fire audits have been completed.

Inspections have been completed by Suffolk Fire and Rescue Service at West Suffolk Hospital and the Newmarket Community Diagnostic Centre.

3.8 Specialist Services

Radiology

Radiology reported:

- 325 incidents during 2025/26.
- 12 incidents (4%) with a health and safety impact.

The main operational risks continue to be staffing pressures and ageing equipment. Five IR(ME)R reportable incidents were managed appropriately and closed by the CQC. No HSE notifiable breaches occurred.

Occupational Health

Occupational Health continues to support staff with:

- Mental health concerns.
- Musculoskeletal conditions.
- Occupational injuries.
- Blood and body fluid exposure incidents.

Forty-four percent of psychological referrals were considered work-related, with workplace relationships being the most common stress-related theme.

Pathology

No significant health and safety issues were reported, and the service remains compliant with accreditation requirements.

Pharmacy

No significant health and safety incidents were reported. Risk mitigation measures continue, including improvements to medicine storage security.

Waste Management

No significant incidents were reported. Minor sharps disposal incidents were investigated and corrective actions implemented.

4. Next Steps

The Trust will:

- Continue embedding Radar Healthcare risk management processes.

- Increase fit-testing capacity across clinical divisions.
- Improve completion rates for fire audits and risk assessment reviews.
- Strengthen interventions particularly early support for those staff impacted by violence, abuse and aggression incidents.
- Continue workplace inspection programmes and Health and Safety Link Person development.
- Monitor identified hotspots for manual handling and musculoskeletal injuries.
- Support managers in implementing the revised Health Surveillance Programme.

5. Conclusion

The Trust continues to demonstrate a mature and proactive approach to health and safety management supported by effective governance structures, improved risk management systems and strong compliance processes. While overall performance remains positive, increasing levels of violence and aggression, moving and handling incidents and slips, trips and falls require ongoing attention.

6. Recommendations

The Board is asked to:

1. Note the contents of the report and assurance provided regarding health and safety performance.
2. Endorse the continued development of the Radar Healthcare risk management framework.
3. Support actions aimed at reducing the impacts and incidents of violence, abuse and aggression towards staff.
4. Endorse targeted interventions in areas with higher rates of work-related musculoskeletal injuries.

6.4. Agenda items for next meeting

To Note

Presented by Jude Chin

6.5. Reflections on meeting

For Discussion

Presented by Jude Chin

**6.6. Date of next meeting - 27 November
2026**

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

7. SUPPORTING APPENDICES

To inform

Presented by Jude Chin

Item 2.1 - Appendix

Strategy scorecard: September 2026

25th September 2026

Compassionate care,
healthier communities

Executive summary

What we've done well

- **Continued delivery of the Trust Strategy**, with tangible progress across all five ambitions, spanning quality, partnerships, workforce, resources and future readiness.
- **Patient experience** remains strong, with positive FFT feedback reaching 97.8% in July 2026, while poor or very poor responses reduced to 0.8%.
- **Long elective waits** have reduced significantly, with 52-week waits falling from 1,086 in September 2025 to 533 in July 2026, a reduction of approximately 51%.
- **Cancer diagnostic performance** has strengthened, with the 28-day Faster Diagnosis Standard improving from 74.2% in September 2025 to 85.2% in March 2026, the latest value available in the raw dataset.
- **Patient safety indicators** have improved overall, with moderate-or-above harm incidents reducing to 1% in June 2026, representing 11 incidents, compared with 4% and 30 incidents in September 2025.
- Care is **experienced as joined up**, with 86% of August respondents agreeing or strongly agreeing that their care was well coordinated between teams and services.
- **Community capacity has grown**, with the community workforce reaching 1,081 colleagues and 903 WTE, representing 20.1% of headcount and 19.3% of WTE in August.
- **Workforce recognition** has gained strong early engagement, with nearly half of colleagues accessing EmpowerU and 2,900 recognition eCards sent since its June launch.
- The Trust remains forecast to **achieve its 2026/27 financial plan**, despite elective theatre disruption, supported by specialty-level activity recovery plans and mitigating underspends.
- **Modernisation** is beginning to demonstrate measurable benefits, with early AVT results indicating a 40% reduction in report-writing time, alongside Copilot rollout and increasing availability of real-time dashboards.

What we could do better

- **Urgent and emergency care** performance requires improvement, with four-hour performance at 69.4% in July 2026, down from 78.2% in March.
- Overall **elective waiting-time performance** remains challenged, with only 65.7% of patients within 18 weeks in July 2026, despite improvements in the longest waits.
- **Elective activity recovery** needs to accelerate, as theatre closures until mid-July left the Trust behind its activity plan and reliant on specialty-level recovery plans.
- **CIP delivery** is behind plan, with 26% of the cumulative programme, delivered by August and a remaining gap requiring further action.
- **Staff advocacy** remains below the desired level, with only 43.4% of Pulse Survey respondents saying they would recommend the Trust as a place to work, compared with 49.1% in December 2025.
- **Workforce motivation** has weakened, with 42.7% reporting that they look forward to going to work, down from 48.3% in April and June 2026.
- **Colleagues' sense of empowerment** needs strengthening, with 48.7% saying they can make improvements happen in their area, compared with 51.3% in June.
- **Sickness absence** remains comparatively high, at 4.86% in August, above the 4.65% 2023/24 baseline, despite a modest improvement from 5.0% in December 2025.

Our strategy at a glance

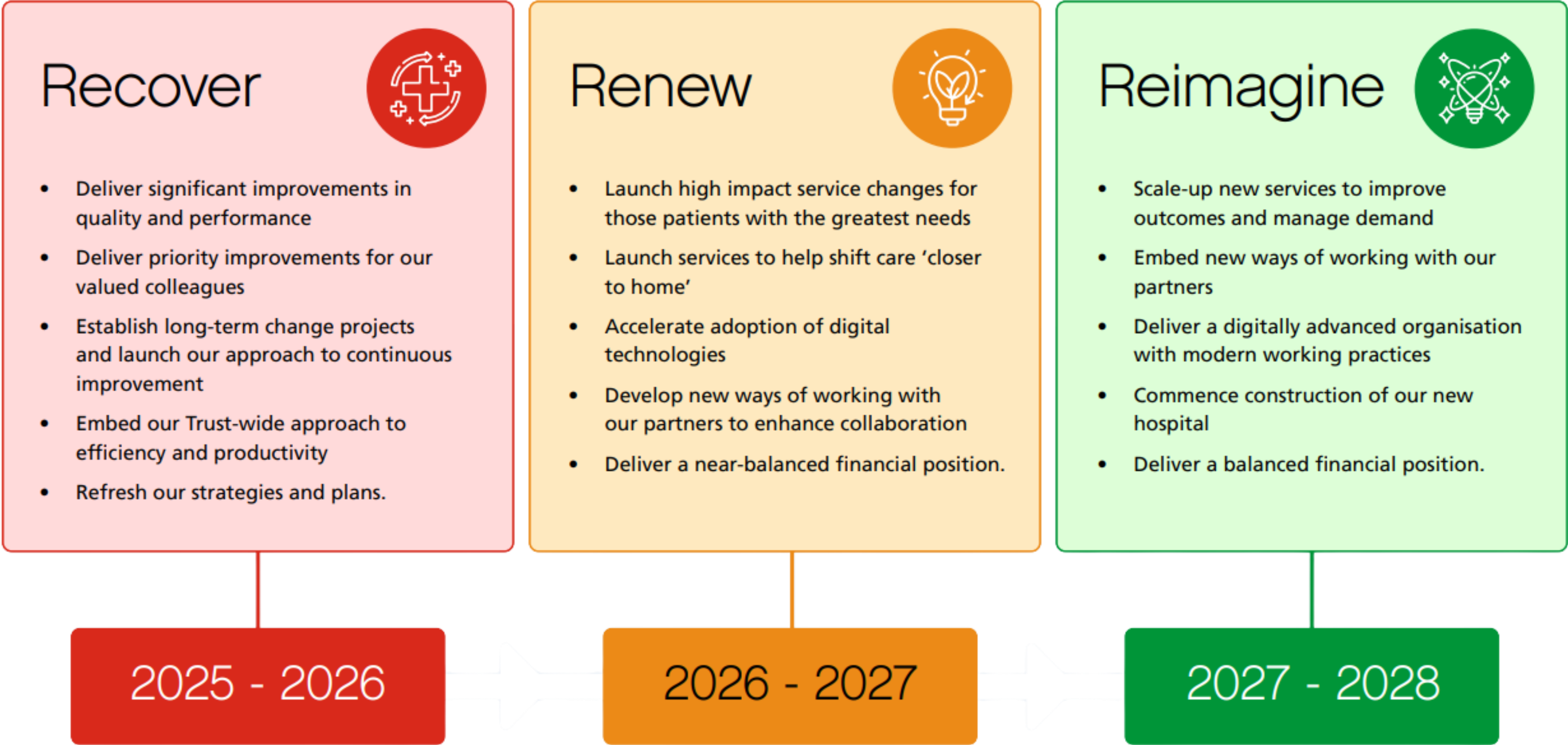
Our strategy sets five ambitions and is powered by our FIRST values

- Fairness
- Inclusivity
- Respect
- Safety
- Teamwork



Compassionate care,
healthier communities

Our roadmap for success



Ambition: High quality care



Please note that for this month, a proof of concept business intelligence dashboard has been created which allows for the manipulation of the quality data. This is only available internally to colleagues, but includes only publicly-available information.

Compassionate care,
healthier communities

Ambition: High quality care

26/27 priority interventions

Improve access, experience, and safety

- Deliver a Quality Improvement project to tackle patients requiring emergency inpatient admission waiting over 12 hours in the ED.
- Roll out ACE (Achieving Care Excellence) across acute and community services to provide a clear framework and assessment for the quality of care.
- Deliver refreshed clinical service strategy, aligned with the FSP programme.

Improvements in the greatest health inequalities

- Agree and implement improvements in the top health inequalities the Trust is to focus on for the next three years.

Embed CQI in everything we do

- Embed Quality Improvement across the Trust as part of our commitment to use QI to improve the way we do everything.
- Implement a new Quality Management System across the Trust.
- Increase the uptake of QI training across the Trust.

Summary

Improve access, experience, and safety

A stakeholder engagement workshop, focused on enhancing understanding of performance data and identifying opportunities for improvement, was successfully delivered to Divisional Leadership Teams in M5. Implementation of the ACE audit platform has been completed, with the programme remaining on track to commence the first ACE accreditation assessment in M9.

Improvements in the greatest health inequalities

The Trust is currently considering its strategic approach to health inequalities, has collated a list of all the health inequalities-related projects underway across the Trust, and will be agreeing health inequalities priorities through the clinical service strategy refresh, which has started.

Embed CQI in everything we do

Delivered a Board development session regarding CQI; implemented QI communications and engagement activity (e.g. presentations at All Staff Update); are applying CQI to Trust-wide priorities (e.g. patient flow); and have drafted a Quality Management System (QMS) for testing.

90-day actions

Improve access, experience, and safety

Hold a follow-up improvement workshop to agree an improvement programme, focused on key drivers of delayed patient flow and identifying evidence-based interventions to improve performance. The ACE audit platform will go live end of September. Full ACE assessments will commence in M9. Complete clinical service strategy engagement ready for document completion by March 2027.

Improvements in the greatest health inequalities

Agree strategic approach to tackling health inequalities, including key priorities for the Trust, based on an assessment of internal and external data, to ensure a clear focus of our work.

Embed CQI in everything we do

On-going implementation of the CQI delivery plan, including: further cohorts of CQI leaders' training; Board-level QI training; agreement of QMS for the Trust; enhancements to the Trust's LifeQI system implemented; continued communications and engagement activities.

Key actions and owners

Improve access, experience, and safety

QIP parameters agreed: Chief Nurse, Dan Spooner, Chief Operating Officer, Nicola Cottington, and Medical Director, Richard Goodwin

ACE: Chief Nurse, Dan Spooner, and Deputy Chief Nurse, Sarah Ward

Clinical strategy: Medical Director, Richard Goodwin, Chief Nurse, Dan Spooner, Director of Strategy and Transformation, Sam Tappenden

Improvements in the greatest health inequalities

Strategic approach to inequalities: Medical Director, Richard Goodwin, and Director of Strategy and Transformation, Sam Tappenden

Embed CQI in everything we do

CQI delivery plan: Director of Strategy and Transformation, Sam Tappenden, and Chief Nurse, Dan Spooner.

Ambition: Joined up services

26/27 priority interventions

Care closer to home

- Embed the shared service delivery model across West Suffolk.
- Implement the Integrated Diabetes Service (IDS) with our partners.
- Ensure the Trust retains its community services contract.
- Work closely with our partners to deliver the Neighbourhood Health Framework.

New models of preventative care

- Implement the Care Management Service (CMS) with our partners.
- Start the implementation of a new integrated model of frailty services with our partners.

Create the conditions for success

- Work closely with partners to support the development of the West Suffolk Alliance.
- Play a greater leadership role in the West Suffolk Alliance as a ‘convenor’ of care.
- Deliver a partnership strategy.
- Enhance our approach to working with General Practice

Summary

Care closer to home

Completed demand and capacity modelling for SSD; urgent community care pathway drafted and reviewed; change management training for INT leads implemented. Responded to ICB Prior Information Notice (PIN) regarding the Integrated Diabetes Service (IDS), due to be commissioned in April 2027. Community Renewal Steering Group established, with task and finish groups set up and delivering actions in line with plan.

New models of preventative care

Suffolk Mobilisation Project Team established. Implementation of model in Mildenhall and Brandon imminent, followed by Newmarket. Work underway to review frailty service provision as precursor to new model.

Create the conditions for success

On-going engagement with WSA through various groups; considering national consultation on new contractual forms; partnership strategy agreed and delivered; regular exec to exec discussions now with Suffolk GP Federation and other partners (e.g. NSFT and ICB).

90-day actions

Care closer to home

- Launch SSD consultation end of September
- Support design of IDS model with partners
- Commence community renewal engagement

New models of preventative care

- Implement CMS in initial West Suffolk areas
- Review frailty provision with external partner

Create the conditions for success

- Consider new contractual forms at MEG
- Start delivering partnership strategy actions
- Continued senior engagement with partners
- Development of delivery plan with GP Fed
- Development of innovation proposal with HIE

Key actions and owners

Care closer to home

SSD consultation: Chief Operating Officer, Nicola Cottington

IDS model: Director of Strategy and Transformation, Sam Tappenden

Community renewal: Director of Strategy and Transformation, Sam Tappenden

New models of preventative care

CMS: Chief Operating Officer, Nicola Cottington

Frailty: Medical Director, Richard Goodwin, and Director of Strategy and Transformation (DST), Sam Tappenden

Create the conditions for success

Contractual forms: DST, Sam Tappenden

Partnership strategy: DST, Sam Tappenden

Executive discussions: all executives

GP Fed plan: DST, Sam Tappenden

Innovation proposal: DST, Sam Tappenden

Ambition: Joined up services

Metric	December 2025	February 2026	April 2026	June 2026	August 2026	Change since Dec 25
‘Lead’ metric Friends and Family Test question: ‘the care I received was well coordinated between different teams and services’*	N/A	N/A	N/A	N/A	63% ‘strongly agree’ 23% ‘agree’ 9% ‘neither agree nor disagree’ 3% ‘disagree’ 2% ‘strongly disagree’	N/A
Evidence that new services, delivered in partnership, are shifting care ‘closer to home’ for specific cohorts of our population	The following services will be monitored in future reports to indicate shift of services ‘closer to home’: - Utilisation of community-based IV pathway for heart failure patients - Outpatient Antimicrobial Parenteral Therapy (OPAT) service utilisation As other new services are implemented, these will be incorporated within this section This includes the future Care Management Service (CMS) and new services anticipated to be commissioned (e.g. integrated diabetes service)					
Increased use of preventative and proactive services	The following services will be monitored in future reports to indicate increased utilisation of preventative services: - The Trust’s future Shared Service Delivery (SSD) model, including: % of virtual ward patients that are ‘step up’ from primary care % of referrals diverted from EEAST					
Proportion of workforce working in community health services	Headcount: 1,038 WTE: 865.07 % by headcount: 19.4% % by WTE: 18.6%	Headcount: 1,062 WTE: 884.47 % by headcount: 19.9% % by WTE: 19%	Headcount: 1,058 WTE: 880.16 % by headcount: 19.3% % by WTE: 18.9%	Headcount: 1,080 WTE: 900.68 % by headcount: 20.14% % by WTE: 19.3%	Headcount: 1,081 WTE: 903.05 % by headcount: 20.14% % by WTE: 19.3%	
Reduction in bed days in target patient cohorts	Metric under development; analysis underway in medicine division to baseline LoS by specific conditions and by West Suffolk locality.					
Percentage of partners reporting positive partnership working.	By March 2027, in line with our strategic stakeholder management approach, we will develop, issue, and analyse feedback from our first partnership satisfaction survey which we are intending to run on at least an annual basis.					

*Information sourced from the new question added to FFT surveys. First two weeks of August data only. 277 respondents. Service areas include inpatients, outpatients, children and young people, maternity, community maternity, and community and integrated services.

Ambition: Joined up services

Trust survey responses (August 2026*)
How well do you agree with this statement: “The care I received was well coordinated between different teams and services”

Service area	Strongly agree	Strongly agree %	Agree	Agree %	Neither agree nor disagree	Neither agree nor disagree %	Disagree	Disagree %	Strongly disagree	Strongly disagree %
Inpatient	26	41%	25	40%	11	17%	0	0%	1	2%
Outpatient	61	79%	15	20%	1	1%	0	0%	0	0%
Children and young people	3	44%	1	14%	1	14%	1	14%	1	14%
Maternity	9	50%	5	27%	1	6%	2	11%	1	6%
Community Maternity	26	52%	9	18%	7	14%	5	10%	3	6%
Community & Integrated Services	49	79%	9	15%	4	6%	0	0%	0	0%
Trust Total	174	63%	64	23%	25	9%	8	3%	6	2%

= Also has a relatable yearly CQC survey

*Partial month (2 weeks data set)

Ambition: Empowered to improve

26/27 priority interventions

Nurture a safe, high performing and inclusive culture

- Embed our behaviours framework with zero tolerance for lack of adherence.
- Embed the anti-racism charter across the Trust
- Refresh our approach to Equality Impact Assessments (EIAs)

Proactively support colleagues' health

- Launch the new digital staff recognition portal, 'Empower U'.

Strengthen leadership to foster autonomy

- Embed the Trust's Accountability and Autonomy Framework.

Summary

Nurture a safe, high performing and inclusive culture

- The framework is now included in our key programmes (e.g. coaching, leadership, mentoring).
- Agreed 'creating an inclusive culture' policy, and developed anti-racism training for community teams.

Proactively support colleagues' health

- Empower U was introduced in June. This is a platform that brings together reward, recognition, and health and wellbeing in one place. Nearly half of the workforce have accessed the platform and 2900 eCards of praise have been sent.

Strengthen leadership to foster autonomy

- Restructure of clinical divisions complete with new configuration live 5th October.
- New Divisional Director roles created as the single, accountable leader.
- Application of Accountability and Autonomy Framework for Executive support of specific services including Medicine Division and Women and Children CIP, Breast service and Emergency Department

90-day actions

Nurture a safe, high performing and inclusive culture

- Continue to deliver awareness sessions regarding the framework and consider how it will be used within appraisal cycles, performance management, and feedback.
- Launch 'creating an inclusive culture' policy, set up anti-racism working group, review and launch 'unacceptable behavior' policy, and ensure EIAs are embedded in strategic decision making.

Proactively support colleagues' health

- In Phase 2, the next steps are to review and enhance the benefits package, and to scope and agree a new benefits package and offer to tender – to include EAP, salary sacrifice, cycle to work, and other additional benefits.

Strengthen leadership to foster autonomy

- Review Performance Review Meeting pack and naming to align with Accountability and Autonomy Framework.
- Commission divisional leadership team development programme to support new leadership and accountability model.

Key actions and owners

Nurture a safe, high performing and inclusive culture

- **Inclusive culture, anti-racism, and EIAs:** Head of Inclusion, Jamais Websmall-Eghan

Proactively support colleagues' health

- **EmpowerU:** Interim CPO (Chief People Officer), Sarah Hodds

Strengthen leadership to foster autonomy

- **Performance Review Meetings:** Chief Operating Officer, Nicola Cottington, and Deputy COO, Matt Keeling
- **Divisional leadership programme:** COO, Nicola Cottington, Medical Director, Richard Goodwin, and Chief Nurse, Dan Spooner

Ambition: Empowered to improve

Metric	Baseline(s)	December 2025	February 2026	April 2026	June 2026	August 2026	Change since Dec 25
‘Lead’ metric Staff and Pulse survey, ‘advocacy’: I would recommend my organisation as a place to work.	2023: 64.9%# 2024: 49.4%#	49.1%#	41.9%*	47.5%*	47.5%*	43.4%*	
Staff and Pulse survey, ‘motivation’: I look forward to going to work*	2023: 57.3%# 2024: 50.8%#	48.2%#	42.7%*	48.3%*	48.3%*	42.7%*	
Workforce Disability Equality Standard: percentage of disabled staff saying their employer has made reasonable adjustments to enable them to carry out their work#	2023: 75.2%# 2024: 72.8%#	2025: 71.9%#					
Workforce Race Equality Standard: ‘staff experience’: percentage of staff reporting personal experience of discrimination#	2023: 16.4%# 2024: 16.3%#	2025: 13.8%#					
NHS Equality Diversity and Inclusion Improvement Plan: percentage of staff saying that they have not experienced harassment, bullying, or abuse from managers in the last 12 months#	2023: 89%# 2024: 88.4%#	2025: 89.9%#					
Staff and Pulse survey, ‘involvement’: I can make improvements happen in my area of work	2023: 56.8%# 2024: 50.6%#	51%#	51.7%*	51.3%*	51.3%*	48.7%*	
Staff sickness absence^	2023-24: 4.65% 2024-25: 4.67% 2025-26: 4.94%^	5%	4.95%	4.91%	4.91%	4.86%	 

*Information sourced from the quarterly ‘pulse’ survey which is collected in April, July, October, and January
#Information provided annually from the national staff survey
^Data is taken from the 31st March at the end of each financial year, and is based on the previous 12 months

Ambition: Responsible with resources

26/27 priority interventions

Achieve a long-term sustainable financial position.

- Implement improvements in the Trust’s corporate infrastructure to improve financial and workforce control processes.
- Develop detailed implementation plans underpinning the medium-term financial model, with the necessary modelling for future years.

Instill shared responsibility for managing resources

- Implement finance enabling strategy to develop the finance team, replace and renew the finance and procurement system, and better equip decision makers in the Trust.
- Implement new approach to integrated workforce and financial insight to support managers to make informed decisions on skill mix, productivity and affordability.

Make efficiency and productivity improvements.

- Ensure the Trust delivers its commitments as per the agreed Medium-Term Plan.
- Ensure the Trust delivers its CIP target in full, with a focus on clinical productivity.
- Enhanced approach to benchmarking to maximise value for money.

Summary

Achieve a long-term sustainable financial position.

The trust is forecast to achieve the financial plan for 26/27, with mitigations for activity income under performance. The Trust is behind it’s activity plan, due to the closure of elective theatres until mid-July. Specialty-level recovery plans have been developed through the Elective Delivery Group.

Instill shared responsibility for managing resources

Finance strategy agreed. The next stage of the finance department transformation is underway, with the new ledger and processes to be in place from December 2026.

Make efficiency and productivity improvements.

Activity recovery plans are in place to (partially) mitigate the under performance. The reduction will hinder progress in productivity metrics, but improvements can be expected to seen in the second half of the year as activity is recovered. The CIP target has not been met in full, but underspends elsewhere mitigate the gap. Work continues to close the CIP gap and to refresh our approach to 27/28.

90-day actions

Achieve a long-term sustainable financial position

The medium term plan for 2027/28 and beyond will be refreshed ahead of the 2027/28 planning round, aligning activity, workforce and financial targets. Implementation of recovery plans.

Instill shared responsibility for managing resources

Go-live with the new finance and procurement systems, ensuring the benefits are fully realised.

Make efficiency and productivity improvements.

Continue to identify efficiency and productivity opportunities, and maximise the available estate to deliver the planned activity. Identification of high-level value improvement opportunities aligned with the 27/28 planning round.

Key actions and owners

Achieve a long-term sustainable financial position

Lead 27/28 planning round: Director of Strategy and Transformation, Sam Tappenden, with Chief Finance Officer, Jonathan Rowell

Recovery plans: Chief Operating Officer, Nicola Cottington, and Medical Director, Richard Goodwin

Instill shared responsibility for managing resources

Implement new systems: Chief Finance Officer, Jonathan Rowell

Make efficiency and productivity improvements.

Lead 27/28 CIP programme: Director of Strategy and Transformation, Sam Tappenden, with Chief Finance Officer, Jonathan Rowell

Ambition: Responsible with resources

Metric	Baseline	December 2025	February 2026	April 2026	June 2026	August 2026	Change
‘Lead’ metric Implied percentage movement in productivity	Q1 25/26: 0.78%	Q2 25/26: 1.32%	Q2 25/26: 1.32%	Q3 25/26: 1.3%	Q3 25/26: 1.3%	Not available	N/A
Sustainable financial position delivered: delivery of plan in-month	N/A	N/A	N/A	Target: -£0.5m Actual: -£1.0m	Target:-£0.1m Actual: -£0.3m	Target: -£0.1m Actual: £0.2m	↑
Cumulative percentage of cost improvement plan (CIP) plan delivered	N/A	N/A	N/A	£1.2m 4%	£4.2m 14%	£7.7m 26%	↑
Average metric score in NHS Oversight Framework	Q1 25/26: 2.51 90/134	Q2 25/26: 2.27 55/134	Q2 25/26: 2.27 55/134	Q3 25/26: 2.39 68/134	Q3 25/26: 2.39 68/134	Q4 25/26: 2.3 66/134	↑ ↑
Unadjusted segment	3	2	2	3	3	2	
Adjusted segment	3	3	3	3	3	3	↑
NHS reference cost score	2024: TBC	2025: 95					↔
% of budget holders trained in financial management	N/A; not yet due, to be phased in from Q4						↔

Notes

- Lead metric has been changed to the NOF metric from ‘Total cost per Weighted Activity Unit of clinical output’
- Some figures provided in-month reflect *when* the metric was reported (e.g. April’s NOF score was reported in March)
- With the NHS Reference Cost Score 100 is the national average. Lower is better. To be updated later this year.
- Budget holder training is an important metric which will be measured as part of the implementation of the new ledger system in q3/4

Ambition: Fit for tomorrow

26/27 priority interventions

Accelerate the adoption of technology

- Improve our critical digital infrastructure and address our technical debt.
- Integrate financial, performance, and workforce modelling and planning to support future transformation.
- Implement and scale-up pilots in Artificial Intelligence.

Improve access to data

- Deliver the data warehouse programme for the Trust.

Modernise the way we work

- Deliver a reduction in backlog maintenance, improved space utilisation, and critical infrastructure improvements across Trust estates.
- Deliver priority digital products to support productivity (e.g. CoPilot)
- Start implementation of the transformation of administration and corporate services programmes.

Summary

Accelerate the adoption of technology

Frontline Productivity Funding applications continue. Implementation of technical debt plan underway with 26/27 funding secured. Pilot of ambient voice technology (AVT) in community completed.

Improve access to data

Ongoing challenges with data warehouse but headway being made with availability of real-time dashboards

Modernise the way we work

New role appointed to support Trust asset management, and significant inroads made to improve estate infrastructure. Initial rollout of Microsoft Copilot is complete, with waiting list in place. Revised desk booking app ready for implementation. First of two strands of transformation of administration programme due to commence in October; planning work underway to identify priority improvements in corporate services ahead of designing future operating model.

90-day actions

Accelerate the adoption of technology

Plan for FY27/28 technical debt improvements and funding requirements.
Business cases for revenue funding for AVT and implementation plans.

Improve access to data

Plan for how we improve visibility of available reports and dashboards, as well as who can access them.

Modernise the way we work

On-going long-term programme to improve asset management and utilization. Identify additional PowerBI dashboards to consolidate visibility of real-time data. Desk booking app development for external users. Digital Maturity Assessment 2026 completion. Implement strands one and two of the transformation of administration programme; complete draft operating model for future corporate services.

Key actions and owners

Accelerate the adoption of technology

Head of service improvement, Guy Hooper and Head of technical delivery, Simon Gilbrook

Improve access to data

Senior BI managers, Jennie Harris and Christine Cherop

Modernise the way we work

Backlog maintenance: Chief Finance Officer, Jonathan Rowell

Priority digital products: Chief Information Officer, Sarah Judge

Administration and corporate transformation: Director of Strategy and Transformation, Sam Tappenden

Ambition: Fit for tomorrow

Metric	2024	2025	2026	Change
'Lead' metric Improvement in digital maturity score of the Trust	2024 Acute: 2.95 / 5.0 Community: 2.65 / 5.0	2025 Acute: 2.71 / 5.0 Community: 2.56 / 5.0	Not available	↔
Total carbon emissions in tonnes*	2019/20: 10,644 2020/21: 10,156 2021/22: 9,978 2022/23: 9,810 2023/24: 10,330	2024/25: 9,820	Not available	↔
Total Gross Internal Area of estate per Worked Activity Unit.	2021/22: 0.92 m2 per WAU 2022/23: 0.82 m2 per WAU 2023/24: 0.76 m2 per WAU	2024/25: 0.64 m2 per WAU#	Not available	↔
Hours saved through modernised working	Hours saved is a developing metric. Early AVT results indicate a 40% reduction in report-writing time, with further Copilot benefits data expected in October 2026. Formal measurement will be established through benefits evaluation.			
Staff satisfaction with digital implementations	Staff satisfaction with digital implementations remains under development as a metric and will be captured through future project evaluation and closure processes.			
Percentage of managers reporting that they have access to appropriate data to support decision making	Baseline data has been captured, with annual reviews planned. 31% have access to appropriate clinical or performance data; 20% financial data, 34% workforce data.			

Metric	Baseline	Dec 2025	Feb 2026	April 2026	June 2026	Aug 2026	Change since Feb 26
Patient uptake of Patient Portal: new registrations per month	2,500	2,994	2,807	2,671	2,618	2,523	7,812

- Digital Maturity Assessments are carried out annually. NHS and EoE averages for 2025 were both 2.38, and data for 2026 will be available in December.
- #The Trust has moved from median to 5th from top upper quartile performance at national level in this estates metric.
- *Emissions figures are presented as tonnes of carbon dioxide equivalent (tCO₂e) and rounded to the nearest whole tonne for clarity. A temporary increase is observed in 2023/24, which is likely attributable to changes in national emissions factors. Includes Scope 1 and 2 emissions.

Item 4.1.1 - Appendices

Appendix A: Pay gap action plan 2025-2026

Actions	Update	Next steps
Increase EDI disclosure rates	In February 2026, the Trust launched it's 'make your profile count' campaign. The aim of this campaign was to increase the number of staff who had updated their equality, diversity and inclusion (EDI) data through ESR. Following the campaign, the percentage of staff who identify as disabled has increased to 8%, up from 7% in 2024–2025, the percentage of people who do not identify as having a disability has increased to 70% from 68% in 2024-2025, and the percentage of colleagues who have not declared or recorded their disability status has decreased from 20% to 17%. Whilst there were increases in disclosure amongst other characteristics, ethnicity disclosure has seen a very small decrease (-0.14%) over the last year, but it remains consistently high at over 95%, meaning the data is still robust and reliable for analysis.	• Work with comms to explore ways that the 'make your profile count' campaign and messaging can be embedded throughout the year so it remains relevant and a consistent call to action/reminder for colleagues to update their EDI information. • Work with the workforce information team to implement automated prompts/messaging on ESR so colleagues are reminded to update their EDI information when they also complete other tasks (such as requesting annual leave and completing mandatory training). • Provide greater understanding and clarity for colleagues around the existing options available within the disability to avoid confusion and ensure accurate recording of information. • Encourage colleagues to share

Actions	Update	Next steps
		their EDI information as a part of our work to reaffirm our commitment to anti-racism and to enhance disability awareness, equity and inclusion.
Work with colleagues in Learning and Development to support the career development of colleagues from underrepresented groups.	The Trust's CEO programme is a positive action initiative to support the career development and progression of underrepresented colleagues within our Trust. The second CEO mentoring programme launched in March 2026. Applications were received from four women and three men. Four applicants were successful (two women and two men). Two of the successful colleagues are from the Global Majority. One of the four successful colleagues identifies as having a disability or long-term health condition. Out of the three colleagues who were unsuccessful, two were from the Global Majority. One of these colleagues was paired with another executive mentor, and the other colleague was offered and accepted coaching with a senior, qualified coach. The final colleague was offered coaching with a qualified workplace coach within the Trust.	• Monitor participant feedback from the programme. • Work with Learning & Development and the Communications team to increase applications for the third CEO Mentoring Programme. • Increase awareness and engagement with existing leadership and professional development opportunities. • Monitor the total number of applications, the number of successful applications and the programme completion percentages of participants on L&D management and leadership programmes by protected characteristic to identify and address any areas of disparity or inequity between different groups of our staff.

Actions	Update	Next steps
Address the bias we are seeing within our recruitment and selection processes.	The following actions have been undertaken during 2025-2026: • Reviewed and strengthened the current recruitment and selection training • Developed an inclusive recruitment toolkit • Restricted access to TRAC, the Trust's recruitment system. Only staff who have completed the recruitment and selection training will have access to TRAC. Access is needed for anyone who is on a selection panel. Prior to this, there was only the requirement for the recruiting managers (the Chair of the panel) to have undertaken this training. • Ensuring that incidents of bias within the recruitment and selection process are dealt with as conduct issues.	• Publish and communicate the new recruitment and selection policy, once it has been approved. • Continue to collate and share workforce recruitment metrics to monitor the impact of implemented actions, and to share real-time, impactful data with managers across the Trust. • Continue to deliver anti-racism training within the Trust •
Develop clearer principles for managers and staff to support and engage with flexible ways of working.	• Not yet started	• Implement the ESR facility to ensure flexible working requests are properly recorded through ESR.
Strengthening the knowledge and promotion of our family friendly policies	• The Trust's family friendly policies have been shared and highlighted throughout the year.	• Work with the Parent and Carer staff network and the Communication team to increase awareness and understanding of these policies and the entitlements within them.
Introduce menopause training for managers by developing	• Initial resources have been developed and are available within the Trust's menopause policy. These	• Full roll out of the training and continuous updates throughout

Actions	Update	Next steps
training modules and online resources.	resources are available on the internet and intranet.	2026-2027.
Create a menopause policy	The policy was introduced in March 2026.	Continue to share the policy to raise awareness and contribute towards reduced stigma and increased confidence in available organisational support.
Update menopause guidelines Review menopause advocate role	Initial guidance updates are underway.	Complete the guidance to support the advocacy of colleagues across the Trust
Promote use of the workplace adjustment request process for menopause-related symptoms Monitor and evaluate impact of workplace adjustments on menopause and other long-term conditions	- The process has been implemented as part of larger workplace adjustments work. - A menopause risk assessment has also been created as additional resource.	Continue the promotion of the workplace adjustment process to increase the awareness and adoption of adjustments for colleagues
Enhance awareness through internal communications campaign aligned to World Menopause Day and Schwartz Round.	- Campaign activity in place, with key events delivered annually - Additional information and events on menopause were included as within the Trust's International Women's Day programme.	- Continue to increase awareness and access to resources. - Increase engagement and attendance to key events on menopause.
Launch menopause café and peer support network	Not yet started	- Launch pilot network - Facilitate regular meetings - Gather feedback relating to the impact of the network.

Menopause action plan update 2026

1.	Introduction
1.1	Menopause is a significant life stage that affects a large portion of the population, yet it remains an area of health and wellbeing that often lacks adequate support and attention. Those that are undergoing menopause experience a wide range of symptoms and challenges, impacting their physical, emotional, and mental health. Despite its prevalence and the profound effect, it can have on individuals' lives, many do not receive the support or resources they need to manage this transition effectively. Recognising the importance of addressing this gap in healthcare, our organisation has undertaken a focused initiative to identify the specific needs and priorities of those experiencing menopause. To gain a comprehensive understanding of the areas where support is most needed, we conducted a survey aimed at capturing the experiences, concerns, and priorities of women going through this life stage. The survey was designed to explore various aspects of menopause, including symptoms management, access to information, and overall wellbeing. By collecting and analysing the data, we aim to identify key areas where enhanced support can be provided to improve the quality of life for women experiencing menopause. This report presents the findings of our survey, highlighting the areas that require immediate attention and support. Our goal is to use this information to inform future initiatives, ensuring that women receive the comprehensive care and resources they need during this critical phase of their lives.
2.	Background context of previous menopause support at WSFT
	In 2020, Debs Crelly, then SOM of Medicine, founded a group called My Pause. This group of women experiencing menopausal symptoms met on an ad-hoc/regular basis as an informal support group where members shared experiences, provided support, and swapped resources and tips. In 2020, these sessions were taken online, and the informal chat sessions were interspersed with question-and-answer sessions by experts on anxiety, bone health and uro-gynae symptoms, or more general talks, such as the one given by a medical herbalist. Additionally, the group raised the profile of and encouraged comment on the consultation on the Women's Health Strategy for England. At the end of 2021, Debs was seconded to the ICS, now ICB, to lead on health and wellbeing with women's health being part of her remit. This led to: • Widening of the membership of the group to the various organisations of the ICB – an invite list of over 100 women and monthly attendance of between 15-50 women • Distribute funding for Henpicked, a private menopause-focused organisation, to train staff to become menopause advocates to support colleagues in the workplace. • Funding research by the University of Suffolk into 'inclusivity in the menopause'. • Workshops for men whose partners were experiencing menopausal symptoms. • Virtual meet, greet and update with Ms Carolyn Harris, deputy leader of Welsh Labour and chair on the All-Party Parliamentary Group on Menopause. There are currently four active menopause advocates in WSFT. Over the last two years, there has been limited outreach and engagement at the Trust, as membership of the online menopause group grew, and staff engagement waned. Debs Crelly left the ICB in mid-2023 and the sessions stopped. Therefore, staff at the Trust lost access to the support this group provided. An increase in enquiries from staff about menopause issues via the menopause advocates has reignited discussion and it is hoped that there will be renewed focus on providing a welcoming environment where staff experiencing this life change can continue to thrive.
3.	Survey Results and analysis
3.1	Internal survey results

The survey (completed in 2024/2025) had a total of 94 respondents over a 3-week period. They were given 6 optional questions to answer ranging from rating their support for menopause across the trust to ranking what sort of support they would find most beneficial, to enhance their wellbeing at work.

Key findings of survey

- Respondents reported not feeling supported to manage their symptoms in the workplace, with an average rating of 2.71 (1 being not very well supported and 5 being very well supported).
- 71% of individuals did not know who the menopause advocates were or what support they could offer individuals in the workforce.
- 30% of respondents knew of the menopause guidelines in the Trust and how to access them with the remaining not knowing or were unsure.
- 92.5% of respondents agreed that line manager training would be most beneficial in supporting individuals with their wellbeing needs in relation to their menopausal symptoms.

Some of the additional comments included:

- *I generally raising awareness generally of the menopause and the symptoms that women experience would be beneficial. Allowing women to feel that they can discuss their menopause without judgement would help.*
- *As new to trust and already in perimenopause at age 54, information/ advice / support would have been welcome in initial induction stage.*
- *I don't think information is easy to access nor do I think the topic is much discussed in the Trust, or within many staff groups. It is not a topic that has ever been raised within my immediate team of consultant colleagues.*
- *Just for people to be aware that some days it is difficult to focus on work and remember things, and aches & pains are normal.*
- *Being able to give menopause as a reason for sick leave. It was not an option last time I was off.*

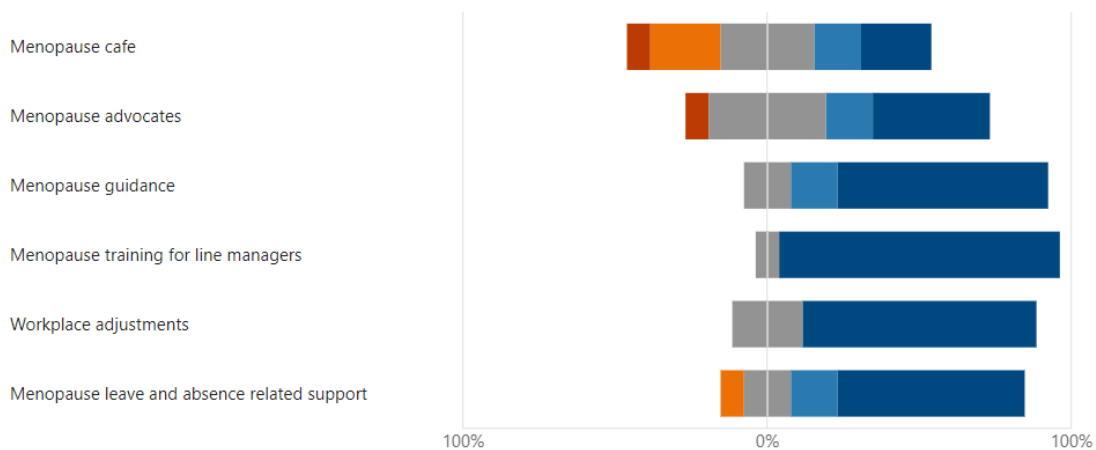
Respondents were also asked to rate 6 types of support they would find most beneficial in enhancing their wellbeing from 1 (least helpful) to 5 (most helpful). The data below illustrates the descending order of results.

1. Menopause training for line managers (92%)
2. Workplace adjustments (76.9%)
3. Menopause guidance (69.2%)
4. Menopause leave and absence related support (61.5%)
5. Menopause advocates (38.5%)
6. Menopause café (23.1%)

4. What type of support would you find most beneficial, to enhance your wellbeing at work?
(1 being least helpful to 5 being most helpful).

[More Details](#)

1 2 3 4 5

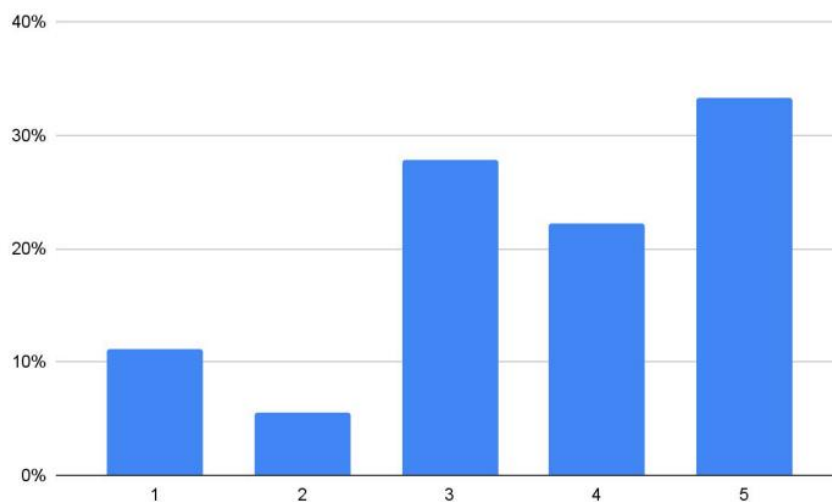


3.2 Additional data results

On 26th June, we invited 'Menopause Reality' to deliver a free pilot of their new virtual reality training around menopause. The team delivered 4 sessions of 1-hour workshops, each with 8 places available on 26th June 2024. 19 people pre-registered, but as word spread, we were inundated with attendees in the afternoon sessions, and had a total of 28 people attend throughout the day.

**MENOPAUSE
REALITY**

Post session - How easily do you think you will be able to discuss the menopause with the patients you care for?



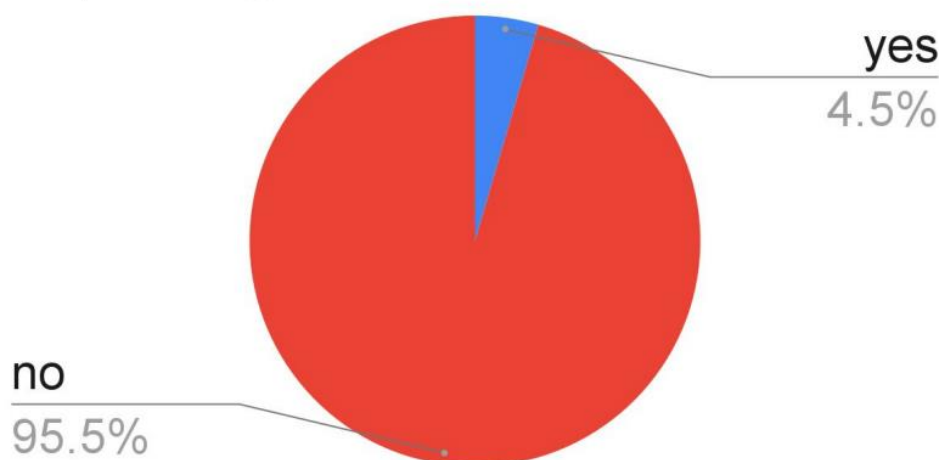
1 = Not at all

5 = Very easily

**67%
increase**

in how easily attendees will be able to **discuss the menopause with patients they care for** after 1 hour session compared with pre session.

Before this session, had you ever had any menopause workplace training?



5. Recommendations for further initiatives and actions

Based on these findings, we have formalised a set of recommendations with clearly defined objectives, priority levels, responsible parties, timelines, resources required, and expected outcomes.

Recommendation 1: Introduce menopause training for line managers.

- To enhance manager capability in supporting individuals with menopausal symptoms, we will provide opportunities for comprehensive learning to be delivered. Equipping line managers with the knowledge and skills necessary to support colleagues experiencing menopause symptoms and to understand how they can support the colleague's sense of wellbeing, whilst at work.

Recommendation 2: Enhance awareness and accessibility of menopause resources.

- Improve awareness and accessibility of menopause-related resources and guidelines on our learning hub within the organisation, in order to increase workforce awareness of available support, leading to better utilisation of resources.

Recommendation 3: Support the further embedding of Workplace Adjustments for Menopause Support

- Encourage both line managers and colleagues to utilise the new workplace adjustments process to better accommodate adjustments for colleagues experiencing menopause symptoms. This will in turn improve workplace comfort and productivity for employees experiencing menopause symptoms.

Recommendation 4: Enhance Menopause Guidance and Advocacy Programmes

- Strengthen the current menopause guidance, ensuring that it is in line with the Trust's incoming policy and guidance framework. Review the structure of the menopause advocate role to ensure strategic alignment with other comprehensive types of wellbeing support, including the wellbeing champion and freedom to speak up champion network.

Recommendation 5: Amend Existing Policies to Support Menopause Leave and Absence Support

- Undergo an exercise to establish which policies need to make further recognition and reference of menopause as a valid reason for sick leave and provide related support. This exercise will aim to reduce stigma around menopause-related absences and increased workforce trust in organisational support.

Recommendation 6: Establish a Menopause peer network.

Create a virtual and physical informal support space to encourage open discussions about menopause in the workplace, to increased sense of community and support among the workforce experiencing menopause.

Implementation plan and timeline

Recommendation	Action Steps (aligned to Trust wellbeing action plan)	Priority Level	Responsible Parties	Timeline & Status	Expected Outcome
1. Introduce menopause training for line managers	- Develop training modules and online resources via the learning hub	Medium	HR, Learning & Development	Partially completed: Initial resources developed and available within policy and on internet and intranet Ongoing: Full rollout and continuous updates through 2026 onwards	Enhanced support from line managers for menopausal colleagues
2. Embedding of workplace adjustments	- Promote use of the workplace adjustment request process for menopause-related symptoms - Monitor and evaluate impact of workplace adjustments on menopause and other long-term conditions	Medium	HR, OD, L&D, Clinical Representatives	Completed: Process implemented. as part of larger workplace adjustments work. Menopause risk assessment also created as additional resource	Improved comfort and productivity for affected colleagues
3. Menopause guidance and advocacy	- Update menopause guidelines - Review menopause advocate role	Medium	HR, Employee Wellbeing	Partially completed: Initial guidance updates underway.	Improved use of guidance and stronger, more aligned advocacy support
4. Policy and absence support	- Revise leave policies - Communicate policy changes	Medium	HR, OD	Completed: Policy introduced in March 2026	Reduced stigma and increased confidence in

		- Track and report impact				organisational support
	5. Menopause Café and peer support network	- Launch pilot network - Facilitate regular meetings - Gather feedback	Low	Menopause Advocates, Staff Support Team	Not yet started: Planning phase. Planned rollout: By December 2026, then ongoing	Increased sense of community and peer support
	6. Enhance awareness and accessibility	- Deliver internal communications campaign aligned to World Menopause Day and Schwartz Round	High	HR, Internal Communications	Ongoing: Campaign activity in place, with key events delivered annually	Increased awareness and improved access to resources
7.	Summary Our aim is to evoke further discussion and agreement on the comprehensive approach to addressing menopause in the workplace, emphasising the need for targeted support and strategic development. With up to 75% of colleagues potentially experiencing menopause symptoms during their careers, it is crucial for the organisation to provide effective support and resources to support future retention. Recommendations include implementing menopause training for line managers, enhancing accessibility to menopause resources, supporting workplace adjustments, and establishing a menopause peer network. By taking these actions, WSFT aims to foster an inclusive work environment that promotes employee well-being, reduces stigma, and improves retention and productivity.					

Emma Taylor

OD Manager- Health and Wellbeing

June 2026

Item 5.3 - Appendices

Norfolk & Suffolk
ICB
Winter Planning

The purpose of the seasonal plan is to bring together all relevant activities across Norfolk and Suffolk ICB health and social care which relates to planning for winter 2025/26 ensuring robust readiness across the system.



Alliance:	West Suffolk
Return Date:	21-Aug-26

Area	Seasonal Variation Plan (list of schemes)	Funding Source	Trigger point* (if relevant) or start date	Expected impact	Lead name / organisation responsible for mobilising scheme	*Organisations to inform when scheme mobilised (if relevant)	Comments
Acute	ED SDEC Optimisation - Pilot overnight Band 6 nurse support to facilitate streaming into EDSDEC and exploration of additional medical cover.	Divisional budget	Nov 2026	Increased utilisation of Emergency Department Same Day Emergency Care, reduced conversion to admission, improved front-door flow and reduced ED crowding.	Medicine Division		Three-month pilot proposed; accommodation options and extended operating hours under review.
Acute	Criteria Led Discharge Expansion	NHSE-funded Band 7 post plus existing resources	Autumn 2026	Reduced length of stay, earlier discharge, improved bed availability and patient flow.	Medicine Division		
Acute	Discharge Waiting Area (DWA) Pathway Expansion	Existing resources	Jan 2027	Increased use of discharge to assess principles through inclusion of last-day antibiotics and TWOC patients, supporting earlier discharge. Use of the full DWA ward footprint for overnight stays.	Medicine Division		Subject to confirmation of operating model, expected throughput and space availability as part of ward reconfiguration.
Acute	Specialty Ownership of Flow Programme	Approximate IT cost of £2,500 per ward for dashboards.	Autumn 2026	Improved visibility of demand by specialty, stronger ownership of patient flow and earlier intervention to prevent delays, including ward and specialty level identification and management of required numbers of Pathway 0 patients and increased weekend discharge activity and improved bed availability across the week.	Tactical Control Centre, Divisional Teams, Business Intelligence		"Ward-level specialty demand dashboards anticipated, estimated IT costs approximately £2,500 per ward."
Acute	Clinical Flow Manager and Escalation Staffing Review	Potentially covered through workforce flexing for Clinical Flow Managers, with dedicated ED escalation shifts estimated at £45k for 3 months.	Nov 2026	Improved operational grip, escalation management and patient movement through the acute pathway.	Medicine Division		
Acute	Standardisation of condition-specific care pathways to reduce length of stay and improve consistency of care	Existing resources	Autumn 2026	Reduced length of stay. Improved standardisation of care. Earlier discharge.	Medicine Division		
Acute	Additional Portering and Escort Capacity	Funding to be identified	Nov 2026	Reduced discharge delays and improved patient transfers throughout the hospital.	Estates and Facilities working with Medicine Division		
Acute	Admission Avoidance Team in ED	TBC	Subject to approval	Avoidance of unnecessary admissions through combined paramedic, Virtual Ward and palliative care support within ED.	Medicine Division to lead, with support from internal and system partners	EEAST	Concept to be developed along the lines of West Herts model. Relationship with existing UCCH will need to be carefully understood.
Acute	Enhanced Call Before Conveyance Model	TBC	Subject to approval	Reduced unnecessary ED attendances and ambulance conveyances through alternative pathway advice.	Medicine Division to lead, with support from internal and system partners	EEAST	Concept to be developed along the lines of West Herts model. Relationship with existing UCCH will need to be carefully understood.
Acute	Surgical Escalation Capacity (DOSAs Beds)	Existing resources	During periods of escalation	Additional short-stay surgical capacity whilst protecting elective activity where possible.	Surgery Division		
Acute	Enhanced Senior Surgical Decision-Making	Deanery-supported workforce / winter funding if required	Subject to approval	Earlier clinical decisions, reduced delays and improved evening and overnight patient flow.	Surgery Division		
Acute	Ward reconfiguration	Some minor works may be required to accommodate relocated services	Phase 1 September 2026 Phase 2 end December 2026	Increased female elective bed capacity for key recovery specialties, enhanced DWA service, enhanced SDEC models to support shift to Future System model. Development of a flexible ward rotating use throughout the year (winter escalation, elective, decant and surge capacity).	All divisions with Estates and Facilities	System partners and Primary Care for enhanced SDEC pathways.	Analysis required to 'right size' SDEC spaces including ward attender activity moving to outpatients if volume is sufficient. DWA model and throughput to be established.
Acute	Trust-Wide Long Stay Patient Review Process	Existing resources	Nov 2026	Formalised 7 to 14 day multidisciplinary reviews leading to proactive management of long-stay patients.	Tactical Control Centre		
Acute	Tactical Patient Flow Escalation and Business Continuity Oversight	Existing resources	Autumn 2026	Coordinated response to operational pressures and maintenance of system resilience.	Tactical Control Centre		

Acute	Enhanced Paediatric Front Door Clinical Decision Making and Advice Service. Utilise consultant programmed activity to provide primary care advice and remote referral support via Microsoft Teams, supported by establishment-level nursing staffing across Ward F1 and Paediatric ED.	Existing resources	Nov 2026	Earlier specialist advice, reduced unnecessary attendances and admissions, improved patient flow and safer management of paediatric demand over winter.	Women & Children's Division	Primary Care	Activity forecasts expected September 2026; scheme delivers improved access to paediatric senior clinical advice.
Acute	Flow Improvement Programme with Stop Stop Go (SSG). Completion of pathway-flow analysis, senior clinical workshop and co-development of a pooled service model to improve patient flow, reduce pathway risk and support winter operational resilience.	£6,000 excluding VAT. Existing transformation funding / to be confirmed	September to October 2026	Improved understanding of pathway constraints, identification of flow risks, development of practical service redesign proposals and enhanced system capacity management.	UEC Delivery Group		Based on SSG proposal covering diagnostic analysis, pathway modelling and pooled service design.
Community	Suffolk Care Management Service Rollout	Allocated programme resources	Autumn 2026	Reduced emergency admissions and bed utilisation among high-intensity service users through multidisciplinary case management.	WSFT Community Division	CMS System Partners	
Community	Optimise Shared Service Delivery Model (INT/EIT/Virtual Ward Integration), including seven-day 08:00 to 20:00 coverage supporting urgent response and discharge pathways. Integration includes INTs, EIT and Virtual Ward services.	Community Division resources	September 2026 consultation, Winter 2026 implementation	Improved urgent community response, improved discharge support, reduced service duplication and strengthened patient flow. Community operating model provides 08:00-20:00, 7-day coverage over winter.	WSFT Community Division		
Community	Virtual Ward Expansion	Community Division resources	Autumn 2026	Expansion of admissions alongside development of additional step-up pathways to support achievement of sustained 80% occupancy.	WSFT Community Division		
Community	Community Assessment Beds (CAB) Optimisation	Existing resources	Autumn/Winter 2026	Strengthen EIT same-day referral pathway from ED/AAU to CAB. Develop acute-to-CAB discharge pathway for patients with complex discharge planning needs. Strengthen CAB delirium pathway and associated workforce competencies. Strengthen community-to-CAB step-up pathways. Continue reduction in "No Criteria to Reside" patients toward regional benchmark of 23%.	WSFT Community Division		
Community	Additional Therapy Support in Acute Areas, Discharge Readiness Support Roles	Funding to be identified	Nov 2026	Increased discharge pace and reduced discharge delays through additional therapy input across acute wards, ED and Rosemary Ward, removal of discharge barriers and acceleration of patient flow.	WSFT Community Division		
Community	Explore the viability of a commissioned Home First discharge support service to provide additional short-term domiciliary care and reablement capacity	Funding to be identified	Options appraisal September 2026. Potential implementation December 2026.	An enabler of existing discharge pathways, particularly Pathway 1, by reducing discharge delays and supporting hospital flow during periods of peak winter demand	DCOO/WSFT Community Division		
Community	Formal engagement with Primary Care Networks and practices to increase clinical capacity, support referral optimisation and maximise utilisation of Virtual Ward step-up pathways.	Existing resources	Autumn 2026	Increased use of admission avoidance pathways, improved Virtual Ward utilisation, reduced avoidable admissions and strengthened community-based care during winter pressures.	WSFT Community Division	Primary Care Networks	Builds on existing Virtual Ward expansion plans and supports system-wide admission avoidance.
Vaccinations	RSV Prevention Programme	National programme funding	Nov 2026	Reduction in avoidable RSV-related admissions among vulnerable infants during winter.	WSFT Women & Children's Division		

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):
If Other, write Provider/Trust Name:

Contact details (email, phone number):

Date:

West Suffolk Foundation Trust

matthew.keeling@wsh.nhs.uk

9/17/2026

Please complete these sections			
Assurance statement			Confirm (Y/N)
			Additional comments or qualifications (optional)
			Blockers/Support requirements (optional)
Governance and executive leadership			
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist		Please complete these sections		
Section B: 26/27 Winter Plan checklist		Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention				
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	Vaccination strategy for 2026/27 includes this and builds on successful approach of previous years
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Vaccination strategy for 2026/27 includes this and builds on successful approach of previous years
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Vaccination strategy for 2026/27 includes this and builds on successful approach of previous years
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Vaccination strategy for 2026/27 includes this and builds on successful approach of previous years
Occupancy and discharge				
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Discharge pathways have been reviewed jointly through the Transfer of Care Hub and community partners. Community Assessment Beds, Home First services, Pathway 1 capacity, Virtual Ward capacity, etc.
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: - coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. - executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. - targeted operational actions to reduce long discharge delays. - Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	The Trust operates seven-day discharge arrangements supported by the Tactical Control Centre, Transfer of Care Hub and community services. Winter-specific initiatives include expansion of capacity, etc.
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Pre-Christmas and holiday period plans include enhanced discharge focus, identification of expected discharges, proactive management of long length of stay patients, use of discharge waiting lists, etc.
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	The Trust has identified a number of admission avoidance initiatives including ED SDEC optimisation, specialty ownership of flow, expansion of ambulatory pathways, review of SDEC operating hours, etc.
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Frailty and admission avoidance pathways continue to be supported through Virtual Ward services, Early Intervention Team provision, Community Assessment Beds, Urgent Community Referrals, etc.
Capacity				
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Workforce planning assumptions include safe staffing reviews, escalation staffing arrangements, redeployment processes and the use of tactical escalation actions aligned to OPEL levels. Winter-specific initiatives include expansion of capacity, etc.
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Divisions have reviewed arrangements for senior decision-making during periods of peak demand. Planned actions include enhanced senior surgical decision-making, specialty ownership of flow, etc.
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Elective capacity planning has been supported through ward reconfiguration proposals designed to increase female elective bed capacity, improve utilisation of inpatient capacity and create flexible capacity, etc.
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Winter mitigation schemes are specifically focused on improving flow, reducing length of stay, reducing admission conversion and improving discharge performance in support of delivery of agreed capacity, etc.
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Community services operate an established escalation framework aligned with Trust OPEL processes. Winter actions include Shared Service Delivery integration, Virtual Ward expansion, Care at Home, etc.
Flow				
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	The Trust operates a comprehensive Tactical Patient Flow Escalation Plan aligned to the national OPEL framework. Defined escalation thresholds, operational actions, senior oversight arrangements, etc.
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Ambulance handover performance is supported through HALO arrangements, Rapid Assessment and Treatment processes, escalation triggers within the Tactical Escalation Plan and joint working, etc.
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Escalation arrangements operate across acute, community, discharge, social care and ambulance services through coordinated OPEL escalation processes, Transfer of Care Hub oversight and support, etc.
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	The Trust's winter programme supports implementation of model discharge principles through enhanced criteria-led discharge, discharge pathway optimisation, long stay patient reviews and support, etc.
Infection Prevention and Control (IPC)				

5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	The Trust maintains a Tactical Infectious Disease Plan and Tactical Patient Flow Escalation Plan which provide arrangements for rapid reconfiguration of physical space, isolation and cohorting	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Tactical Infectious Diseases Plan has been reviewed. Core Resilience Team for High Consequence Infectious Diseases established.	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	The Trust maintains an Infectious Disease Plan which includes requirements for PPE deployment, FFP3 fit testing and escalation arrangements during infectious disease outbreaks. A review of	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	The Trust maintains a risk-based patient cohorting and isolation approach through its Tactical Infectious Disease Plan. This includes defined escalation arrangements for patient isolation, cohorting	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	The Trust operates established Strategic, Tactical and Operational command arrangements alongside a structured Patient Flow and Tactical Control Centre function. Clinical and operational le	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	Real-time monitoring is undertaken using the national OPEL framework and e-Shrewd platform across Suffolk, supported by multiple daily capacity reviews, escalation meetings and defined a	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Mutual aid processes are established through system and regional escalation arrangements and may be activated where required through established operational command structures.	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Business continuity plans are maintained and exercised in accordance with Trust EPRR arrangements and support delivery of services during periods of sustained operational pressure.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	Severe weather contingencies form part of Trust business continuity and winter preparedness planning, with escalation routes established through tactical and strategic command arrangements	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Industrial action plans remain under review and can be activated should any workforce-related risks emerge during the winter period.	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Staff wellbeing is supported through established occupational health, wellbeing and leadership arrangements, alongside workforce escalation processes designed to maintain safe staffing and	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed by the Accountable Officer and Chair.

Trust / Provider Name: West Suffolk NHS Foundation Trust

Provider CEO name: Dr Ewen Cameron

Date reviewed: 9/25/2026

Provider Chair name: Jude Chin

Date reviewed: 9/25/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Nicola Cottington, Executive Chief Operating Officer: nicola.cottington@wsh.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming the:

Yes

Please confirm date reviewed

9/25/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance
		Awaiting assessment

EIA Assessment template

There may be intersectionality between characteristics e.g. an older (age) disabled (disability) Black (race) woman (sex) with caring responsibilities (socially excluded), so try to consider how people with intersectional characteristics may be affected.

Protected characteristic and socially excluded groups	Potential positive impact(s) or no impact	Potential negative impact(s)	Mitigating actions to address identified negative impact(s)	Person responsible for implementing mitigating action(s)	Timeline	Opportunity for further equity?
	Will this change be good for people? Think about positive elements it will bring to people within the protected characteristic groups	How could certain groups be negatively impacted? Will it be more difficult for older people? Will it create potential barriers for people with disabilities? Will it be more difficult for people living in poverty?	What can we do to reduce the likelihood of negative impacts? How will we monitor this?			Is there anything we can do to improve equity? Any ideas about what could be done in an ideal world?
Age	Expanded SDEC, Virtual Wards and discharge pathways may reduce hospital stays and improve outcomes for older people.	Patients may need to access Urgent and Emergency Care (UEC) services at different times of the day and week through age related factors such as increased dependence on public transport or people of working age being more likely to attend during evenings and weekends. Older people may have difficulty engaging with digital monitoring.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods. Alternative monitoring arrangements, carer involvement where appropriate, provision of equipment and non-digital escalation routes, monitoring uptake by demographic group.	ED Leadership Team	Autumn 2026	
Disability includes physical ill health, long-term health conditions, mental ill health and learning disabilities. Mental ill health includes, but is not limited to anxiety, stress, depression, bipolar, eating disorders, OCD, PTSD). Also includes neurodiversity which includes, but is not limited	Community pathways and admission avoidance schemes may reduce disruption for people with long-term conditions and disabilities.	People with mental health presentations and diagnoses are more at risk of extended waits for urgent and emergency care. Patients who are neurodiverse, those with dementia and anxiety who struggle with busy, noisy environments may need extra support in cases where there are extended wait	Proactive escalation of any patient experiencing extended waits for specialist mental health services and close liaison with mental health provider to ensure capacity is available through the winter period. Training for staff around supporting these patients.	Head of Nursing for Mental Health, linking in with Norfolk and Suffolk NHS Foundation Trust ED Manager and Matron	Autumn 2026	Monitor waits for patients requiring mental health assessment, ensure mental health pathways are represented in escalation arrangement, consider impact of discharge acceleration on

to dyslexia, dyspraxia, ADHD and autism		times. Some patients with cognitive impairment, dementia or learning disabilities may require support to participate in Virtual Ward pathways. Changes in ward location or pathways may affect accessibility and familiarity for some patients.	Alternative monitoring arrangements, carer involvement where appropriate, provision of equipment and non-digital escalation routes, monitoring uptake by demographic group. Accessible wayfinding, clear communication regarding ward relocations, review of accessibility implications before implementation.			patients with complex mental health needs.
Gender reassignment including trans, non-binary and gender non-conforming people		Potential risk that patients feel they cannot comfortably present for a problem that is not commonly found in their particular gender.	Ensuring urgent and emergency care pathways are able to assess, diagnose and treat all patients equally regardless of gender reassignment, ensuring a positive patient experience.	All UEC Leadership Teams	Autumn 2026	
Marriage and civil partnership (assessment only required for issues affecting employment/workforce)		Potential for assumptions to be made/role stereotyping around main income earner for people who are married/within a partnership when allocating additional shifts during winter period.	Line management incorporating reasonable requests for working patterns that take into consideration an individuals status.	All UEC Leadership Teams	Autumn 2026	
Pregnancy and maternity	Enhanced senior clinical decision-making and improved patient flow may reduce delays in accessing assessment and treatment.	Risk that pregnancy/maternity related presentations and diagnoses are more at risk of extended waits for urgent and emergency care due to insufficient capacity over the winter period.	Ensuring capacity is planned to match known changes in demand profile and that robust escalation processes are in place. Consider whether referral to maternity assessment unit is appropriate?	Women's & Children's Divisional Leadership Team	Autumn 2026	

Race	Improved flow and reduced waits may improve patient experience for people requiring interpretation services.	Patients for whom English isn't their first language may struggle with extended waits and potential lack of communication	Ensure availability of Language Line device on wheels in order to communicate via video interpreter	ED Manager and Matron	Autumn 2026	
Religion and belief		Patients observing religious events may need to schedule seeking non-life threatening urgent care around event days.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods.	ED Leadership Team	Autumn 2026	
Sex	Positive impact from increased female elective bed capacity.	Risk that sex-specific related presentations and diagnoses are more at risk of extended waits for urgent and emergency care due to insufficient capacity over the winter period, for example the gynaecology assessment unit has a single assessment space	Ensuring capacity is planned to match known changes in demand profile and that robust escalation processes are in place.	All UEC Leadership Teams	Autumn 2026	
Sexual orientation		Evidence suggests that compared to completely heterosexuals, mostly heterosexual and bisexual adults are more likely to report emergency departments as a usual source of care. Sexual minorities (mostly heterosexual, bisexual, gay/lesbian) are also more likely than completely heterosexuals to delay seeking care for reasons of not wanting	Monitoring waiting times and access to care (both planned and unplanned) by sexual orientation to ensure that disparities in waiting times are not causing to people to defer seeking care to a UEC setting. Patient experience data should be similarly correlated.	Deputy Chief Operating Officer	Winter 2026/27	

		to bother a healthcare provider, bad prior healthcare experiences, and being unable to get an appointment.				
Caring responsibilities (unpaid)		Patients who are carers may need to access Urgent and Emergency Care (UEC) services at different times of the day and week to fit in with their carer responsibilities. Earlier discharge may increase pressure on unpaid carers.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods. Carer assessment, early discharge planning, involvement of social care and safeguarding teams, monitoring delayed discharge causes by demographic group.	ED Leadership Team	Autumn 2026	
Socio-economic background people living on low income, no or low paying occupation/minimal or no education and deprived social background	Admission avoidance, community assessment beds and Home First models may reduce travel and financial burden associated with hospital attendance.	Patients may need to access Urgent and Emergency Care (UEC) services at different times of the day and week through socio-economic related factors such as increased dependence on public transport or people of working age being more likely to attend during evenings and weekends. Patients on lower incomes may have reduced access to informal care networks who can support with care upon discharge. Some patients with cognitive impairment, dementia or	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods. Alternative monitoring arrangements, carer involvement where appropriate, provision of equipment and non-digital escalation routes, monitoring uptake by demographic group. Carer assessment, early discharge planning,	ED/Discharge Leadership Team	Autumn 2026	

		learning disabilities may require support to participate in Virtual Ward pathways. Some patients may have limited home support or unsuitable housing.	involvement of social care and safeguarding teams, monitoring delayed discharge causes by demographic group.			
Health inclusion groups and socially excluded populations rural and isolated communities, homeless people, Gypsy, Roma, and Traveller communities, people in contact with the justice system, migrants and sex workers. See the EIA guidance for a full list of factors to consider within this section	Greater community-based care may improve access for vulnerable and excluded populations.	Patients may need to access Urgent and Emergency Care (UEC) services at different times of the day and week through social exclusion related factors such as increased dependence on public transport or people of working age being more likely to attend during evenings and weekends. Homeless patients or those in insecure accommodation may struggle to access Home First pathways.	Ensuring all services are available 24/7 and that available workforce matches Emergency Department demand profiles to ensure extended waits are not correlated to particular time periods. Carer assessment, early discharge planning, involvement of social care and safeguarding teams, monitoring delayed discharge causes by demographic group.	All UEC Leadership Teams	Autumn 2026	